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THE CHILD CANNOT WAIT

A NATIONAL PROGRAMME OF ACTION ON THE FOLLOW-UP TO THE WORLD SUMMIT FOR CHILDREN

ACCRA
JUNE, 1992

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GOVERNMENT OF GHANA

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Accra
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PREFACE

The World Summit for Children, convened in September, 1990 was the realization of the desire of many progressive peoples and nations including Ghana to focus attention, at the highest level, on the urgent needs of millions of children all over the world, particularly in developing countries who suffer much unacceptable deprivations and hardships. On that historic occasion, the World Declaration and Plan of Action on the Survival, Protection and Development of Children was adopted. This significant initiative symbolised the commitment and dedication of the international community to the achievement of goals for the benefit and development of children in the 1990s.

Ghana has already demonstrated that it can rise to the challenge of the Summit. Being the first country to ratify the Convention on the Rights of the Child, Ghana has consistently formulated viable policies, strategies, and programmes, which give expression to its avowed commitment to meeting the needs of our children. In this regard, major reforms have been made over the past five years in the system of education and health services with emphasis on primary health care. Furthermore, attention is also being paid to nutritional problems of children, through research, nutrition education, increased availability and use of appropriate weaning foods and supplementation in the case of micronutrient deficiencies.

The National Programme of Action (NPA) has been prepared in accordance with the guidelines for follow-up action to the World Summit, as set out in the Plan of Action for Implementing the World Declaration on the Survival, Protection and Development of Children. It marks a major step forward in our continuing effort to improve the condition and prospects for children and, indeed, all Ghanaians. The goals, strategies and activities which are outlined in the following pages represent a timely articulation of Ghana's long-term social development priorities. Furthermore, the National Programme of Action is expected to serve as

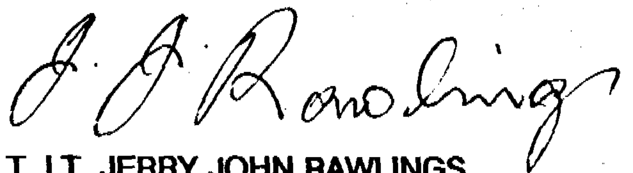
an important point of reference for development policies and initiatives in Ghana. It will also be an integral part of our social development priorities within major economic policies and the Public Investment Programme.

The agenda has been set, the actions and actors have been identified.

We look forward to a dialogue with our development partners, during the course of 1992 and beyond, on the concrete possibilities for expanded cooperation.

The needs of children, and especially of those millions who are still living and dying of malnutrition and preventable diseases should have first claim on the resources of the world.

It is time for us to honour the pledge we have made to our children.



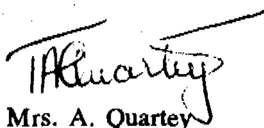
FLT. LT. JERRY JOHN RAWLINGS
CHAIRMAN
PROVISIONAL NATIONAL DEFENCE COUNCIL

ACKNOWLEDGEMENTS

The National Programme of Action (NPA) is the product of a collaborative and sustained effort led by the Government of Ghana (GOG). In May 1991, a Multi-Sectoral Taskforce (MSTF) was established by the Secretariat of the Provisional National Defence Council (PNDC) and mandated to prepare the NPA for presentation to the Council. The membership of this Taskforce included representatives from the following institutions: the Ghana National Commission on Children (GNCC), the National Council on Women and Development, the National Development Planning Commission, the Ministries of Finance and Economic Planning, Education, Health, Agriculture, Mobilisation and Social Welfare and Local Government, the Ghana Water and Sewerage Corporation, the Secretariat of the Committees for the Defence of the Revolution, the 31st December Women's Movement and the Ghana Association of Private Voluntary Organisations for Development. The members are identified by name in Appendix A. The GNCC was designated as the secretariat of the Taskforce. In addition, the United Nations Children's Fund (UNICEF) provided technical and financial assistance to support the preparation of the NPA.

The first draft of the NPA was prepared under the supervision of the MSTF by a group of consultants comprising Mr. W. Tengey (coordinator; children in especially difficult situations, advocacy), Nii Boi Ayibotele (water supply and sanitation), Mr. S. K. Atakpa (education), Dr. H. Jackson (economics) and Ms. E. Tetteh (health). Inputs for the preparation of the second and third drafts of the NPA were provided to the MSTF by the same group of consultants with the exception of Ms. Tetteh who was replaced by Dr. B. M. Ababio. Mr. Y. Adu-Boahene (Continental Consultants, GH) was responsible for the costing exercise and the formulation of a financing strategy. Dr. C. Kohlmeyer of the SPRING Programme at UST-Kumasi guided members of the MSTF through two phases of the Goal-Oriented Perspective Planning and Programming Exercise (GOPERS). Finally, comments were made on the third draft of the Programme of Action by the UNDP, UNFPA, WHO and the World Bank.

The NPA was produced in a relatively short period of time because of the concern and commitment of the institutions and individuals involved in its preparation. We have all been motivated by a strong sense of responsibility to the children of our country and stimulated by the prospect of contributing to a better future for them. For our part, we are ready to translate intentions into reality.



Mrs. A. Quartey
Chairperson
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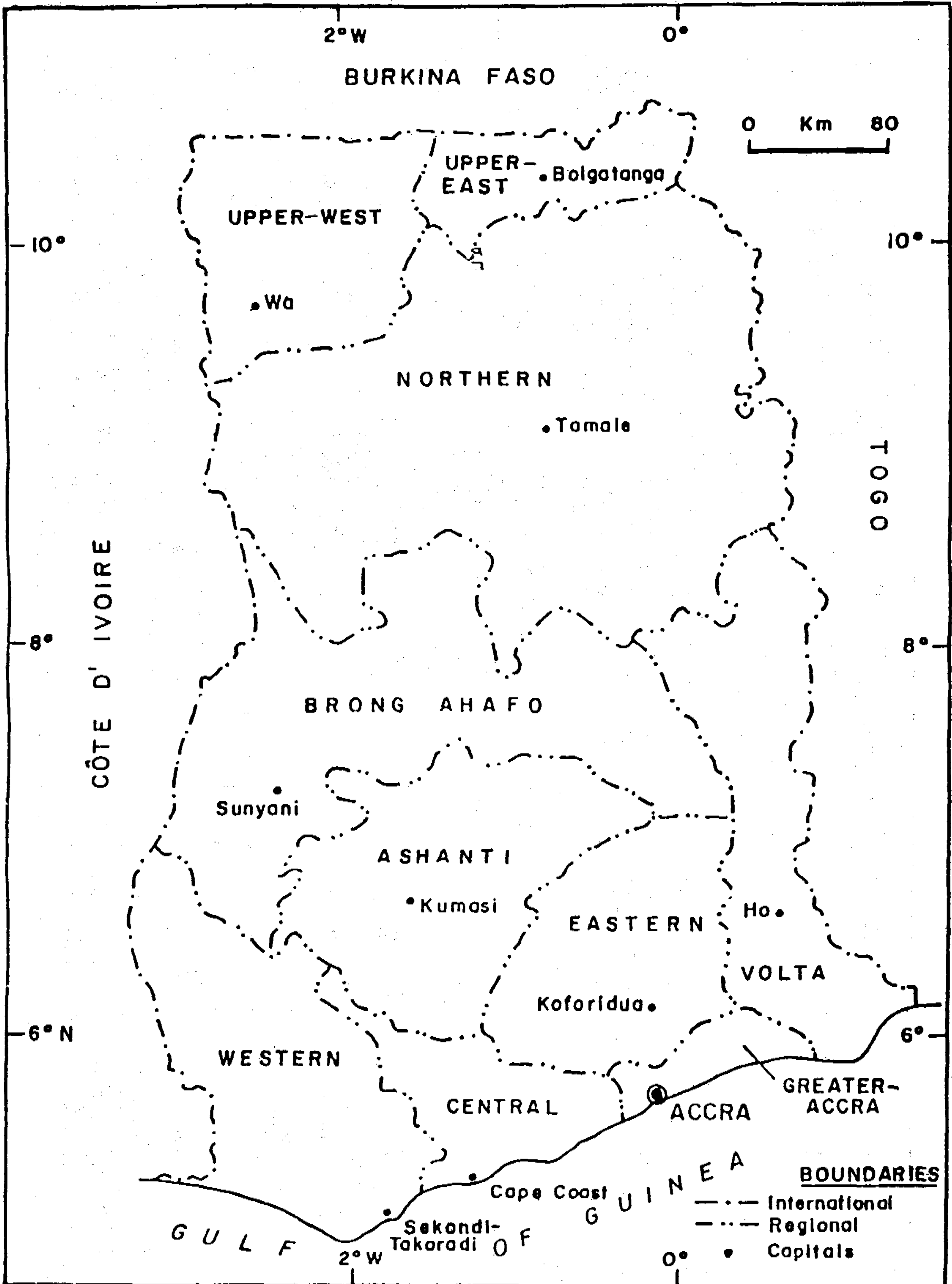

The Administrative Regions of Ghana

GHANA: BASIC SOCIAL AND ECONOMIC DATA

Human Development Index, 1992: 0.310 (119th in the world)

Total Population, 1992 (est.): 15.7 million
Total Child Population (0-4), 1992, (est.): 3.0 million
Total Child Population (0-14), 1992, (est.): 7.2 million

Infant Mortality Rate (IMR), 1988: 77/1000 live births
Under-Five Mortality Rate (U5MR), 1988: 155/1000 live births
Percentage of Low Birthweight (<2.5 kg.), supervised deliveries, 1990: 24
Percentage of Malnutrition (children under five who are two or more standard deviations below the NCHS reference median), 1988:

Wasting (weight-for-height)	7.9
Stunting (height-for-age)	31.0
Underweight (weight-for-age)	20.3

Percentage of Children Under-One Immunised (DPT3), Dec. 1991, (est.): 39
Percentage of Oral Rehydration Therapy (ORT) Use, 1988: 39.6
Percentage Breastfeeding, 1988:

4-5 months after birth: 92.4
24-25 months after birth: 19.2

Primary School Enrolment Ratio (net, percentage), 1990: 65
Primary School "Wastage" Rate (percentage of grade one), 1988-89: 40
Percentage Literacy (9-14 years), 1988:

National:	11.1
Female:	10.4
Male:	11.8

Percentage Literacy (9 years and above), 1988:

National:	32.5
Female:	23.0
Male:	42.0

Gross Domestic Product (GDP), 1991, (est.): USD 5.7 billion
Average Annual Growth Rate of Real GDP (percentage), 1988-90: 4.7
GDP Per Capita, 1991, (est.): USD 375
Total External Debt, 1990: USD 3.5 billion
Debt Service Ratio, (percentage of exports of goods and services), 1991: 30
External Assistance, (pledges), 1991: USD 970 million
External Assistance, (est. commitments), 1991: USD 850 million
Exchange Rate (USD), 23 June 1992: C412

Sources: Alderman, 1991; Ghana Demographic and Health Survey, 1989; Ghana Living Standards Survey, 1989; Ghana Statistical Service; MFEP, Budget Speech of the PNDC Secretary, 1992; MOE, PBME Division, 1992; MOH, MCH/FP Annual Report, 1990; UNDP, Human Development Report, 1991, 1992; World Bank, Ghana: Progress on Adjustment, 1991, World Debt Tables, 1991a, World Development Report, 1991b

TABLE OF CONTENTS

page

Preface i

Acknowledgements iii

Map of Ghana iv

Ghana: Basic Social and Economic Data v

List of Tables vii

List of Acronyms viii

Executive Summary x

Priority Plan of Action for Children: 1993-97 1

Introduction 5

Chapter One

The Evolving Situation of Children and Women 9

Chapter Two

The Broad Framework for Action: A Human Development Strategy for Ghana 33

Chapter Three

The Outline of a Better Future for the Ghanaian Child: Goals for the Year 2002 38

Chapter Four

Sectoral Programmes of Action 41

Chapter Five

Financing the National Programme of Action 114

Chapter Six

Maintaining the Momentum: Leadership for Action 124

Annexes

A: Membership of the Multi-Sectoral Taskforce (MSTF) 133

B: The Framework for Costing 134

List of References 137

LIST OF TABLES

page

Table 1.1
Major Causes of Infant Mortality 10

Table 1.2
Major Causes of Under-Five Mortality 10

Table 1.3
Infant and Child Mortality by Regional and Rural-Urban Residence, 1978-87 12

Table 1.4
Trends in Infant and Child Mortality 12

Table 1.5
Proportional Morbidity Ratio (PMR) for Selected Diseases 13

Table 1.6
Occurrence of Selected Diseases 13

Table 1.7
Number of Pre-Schools and Enrolment by Region and Sex, 1987/88 16

Table 1.8
Dropouts: Primary/Junior Secondary School Cohorts by Sex, 1978/79-1987/88 17

Table 1.9
Registered Disabled Persons in Ghana by Disability and Gender, 1986 19

Table 1.10
Disabled Children by Age and Sex (Absolute Figures), 1980 20

Table 1.11
Proportion of Teenagers Among Those Attending Antenatal Clinics, 1987-90 20

Table 1.12
Drug Seizure Returns 22

Table 1.13
Literacy and Numeracy Rates by Locality (Percent) 25

Table 5.1
National Programme of Action: Summary of Costs 114

Table 5.2
Projected Real GDP and Expected Share of Social Sectors, 1993-97 118

Table 5.3
National Programme of Action: Summary of Financing Structure 120

Table 5.4
National Programme of Action: Financing Gap 122

Table 6.1
A Monitoring Framework for the National Programme of Action (NPA) 130

LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infection
CCA	Community Clinic Attendant
CCCE	Caisse Centrale de Cooperation Economique
CDD	Control of Diarrhoeal Diseases
CDR	Committee for the Defence of the Revolution
CEDS	Children in Especially Difficult Situations
CHW	Community Health Worker
CIDA	Canadian International Development Agency
CSD	Child Survival and Development
DHMT	District Health Management Team
DPT	Diphtheria/Pertussis/Tetanus Vaccine
DCBI	District Capacity Building Initiative
DCD	Department of Community Development
DPBU	District Planning and Budgeting Unit
DRHCI	Department of Rural Housing and Cottage Industries
DSW	Department of Social Welfare
ECD	Early Childhood Development
EPC	Environmental Protection Council
EPI	Expanded Programme on Immunization
ERP	Economic Recovery Programme
ESA	External Support Agency
GBC	Ghana Broadcasting Corporation
GDHS	Ghana Demographic and Health Survey
GDP	Gross Domestic Product
GES	Ghana Education Service
GFS	Ghana Fertility Survey
GLSS	Ghana Living Standards Survey
GNCC	Ghana National Commission on Children
GNP	Gross National Product
GOG	Government of Ghana
GSMP	Ghana Social Marketing Programme
GSS	Ghana Statistical Service
GWSC	Ghana Water and Sewerage Corporation
HDI	Human Development Initiative
HDR	Human Development Report
HDS	Human Development Strategy
IDD	Iodine Deficiency Disorder
IDWSS	International Drinking Water Supply and Sanitation Decade
IE&C	Information, Education and Communication
IFAD	International Fund for Agricultural Development
IMF	International Monetary Fund
IMR	Infant Mortality Rate
ITTU	Intermediate Technology Transfer Unit
JSS	Junior Secondary School
KAPB	Knowledge, Attitudes, Practices and Behaviour
KVIP	Kumasi Ventilated Improved Pit Latrine
MCH/FP	Maternal and Child Health/Family Planning
M&E	Monitoring and Evaluation
MFEP	Ministry of Finance and Economic Planning
MLG	Ministry of Local Government
MMR	Maternal Mortality Rate
MMSW	Ministry of Mobilization and Social Welfare
MOA	Ministry of Agriculture

MOE	Ministry of Education
MOH	Ministry of Health
MTADP	Medium-Term Agricultural Development Programme
MWH	Ministry of Works and Housing
NBSSI	National Board for Small-Scale Industries
NCHS	National Centre for Health Statistics (U.S.)
NCWD	National Council on Women and Development
NDPC	National Development Planning Commission
NDPF	National Development Policy Framework
NGO	Non-Governmental Organization
NMIMR	Noguchi Memorial Institute for Medical Research
NSMC-CSD	National Social Mobilisation Committee for Child Survival and Development
NNS	National Nutrition Survey
NPA	National Programme of Action
NVTI	National Vocational Training Institute
NYOC	National Youth Organising Committee
O&M	Operation and Maintenance
OAU	Organization of African Unity
OPD	Outpatient Department
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PAD	Policy Analysis Division (MFEP)
PAMSCAD	Programme of Actions to Mitigate the Social Costs of Adjustment
PBME	Planning, Budgeting, Monitoring and Evaluation Division (MOE)
PFP	Policy Framework Paper
PEM	Protein Energy Malnutrition
PHC	Primary Health Care
PHN	Population, Health and Nutrition
PIP	Public Investment Programme
PMR	Proportional Morbidity Ratio
PNDC	Provisional National Defence Council
RCC	Regional Coordinating Council
RHMT	Regional Health Management Team
RPCU	Regional Planning and Coordinating Unit
RSGC	Report on the State of Ghanaian Children
RWS/S	Rural Water Supply and Sanitation
SAP	Structural Adjustment Programme
SDHS	Strengthening of District Health Systems Initiative
SOE	State-Owned Enterprise
SSS	Senior Secondary School
SMC-CSD	Social Mobilisation Committee for Child Survival and Development
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
TT	Tetanus Toxoid Vaccine
U5MR	Under-Five Mortality Rate
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VLOM	Village Level Operation and Maintenance
WCEFA	World Conference on Education for All
WHO	World Health Organisation
WIFA	Women-in-Fertile Age
WRRI	Water Resources Research Institute
WSRP	Water Sector Rehabilitation Plan
WS/S	Water Supply and Sanitation

EXECUTIVE SUMMARY

Background

At the time it was held in September 1990, the World Summit for Children represented the largest assembly of Heads of State and Government in history. It was also unique because commitments were made by nations and the international community to achieve concrete goals for children by the year 2000, embodied in a Declaration and Plan of Action. The latter were signed by Ghana's Head of State, Flt. Lt J. J. Rawlings, on 21 April, 1991.

The ten-year National Programme of Action/NPA (1993-2002), prepared as the follow-up to the World Summit, builds upon and imparts greater momentum to efforts already underway to improve the wellbeing of Ghanaian children. It contains a Priority Plan of Action: 1993-97 (immediately following the executive summary) which identifies those goals, objectives, strategies and activities within the broader NPA which can most rapidly and effectively respond to the essential needs of children in the medium-term. The wider framework of the Programme of Action provides a situation analysis of children and women in Ghana (Chapter One); delineates a supportive configuration of development policy based on the Human Development Strategy/HDS for Ghana (Chapter Two); sets out specific goals which are achievable within the timespan of a decade (Chapter Three); proposes concrete sectoral programmes (Chapter Four); summarises resource requirements and possible sources of financing (Chapter Five); and suggests ways of monitorihg progress and sustaining implementation over the programme period (Chapter Six).

Introduction

A consensus has been emerging in the international community on the purpose and promotion of development in the 1990's, influenced by the experiences of the 1980's which have been described as the "Lost Decade" for much of the Third World, especially sub-Saharan Africa. The tremendous difficulties encountered elicited a concerted response from the international community based on a prescription of stabilisation and adjustment policies and programmes. Despite some successes, it became apparent in the mid-to-late 1980's that the criteria of development reflected in the proposed policies needed to be modified to encompass objectives reflecting improved living standards as well as creditable macroeconomic performance.

The evolution of events on the global stage and sub-Saharan Africa have been reflected in Ghana. In the early 1980's, the worsening socio-economic situation in the country led to the launching of a comprehensive Economic Recovery Programme (ERP), designed to stabilise the macroeconomic situation, restore sustained economic growth and contribute to improved living standards. The GOG also initiated a Programme of Actions to Mitigate the Social Costs of Adjustment (PAMSCAD) in 1987 to assist vulnerable groups such as women and children. In addition, Ghana has recently become a key participant in the UNDP/UNICEF Human Development Initiative (HDI) which has led to the preparation of a Human Development Strategy (HDS) for Ghana ("Making People Matter", NDPC, 1991).

The preparation of the NPA can be seen as a further contribution to the elaboration of a long-term perspective on national development. Consistent with the mandate for the Programme of Action, the target group is children, as defined in the United Nations Convention on the Rights of the Child, that is, "....every human being below the age of eighteen years unless, under the law applicable to the child, majority is attained earlier," (Article 1). The NPA focuses, however, on children fifteen years of age or younger who have been identified as the most vulnerable segment of the child population in Ghana. It has also been formulated within the conceptual framework of human development (which is discussed below), to better integrate children's concerns with the broader issues of development policy.

Chapter One - The Evolving Situation of Children and Women in Ghana

The Situation of Children

According to the GDHS (1989), the infant and under-five mortality rates for Ghana are 77 and 155 per 1000 live births, respectively. These national figures, however, conceal significant regional as well as rural-urban variations. The same survey reveals that the infant mortality rate ranges from 58 per 1000 live births in Greater Accra Region to 138 per 1000 live births in Central Region. Similarly, infant and under-five mortality rates are about 30 and 24 percent higher, respectively, in rural compared to urban areas. The major causes of under-five mortality are, in descending order of importance, measles, pneumonia, low birthweight, malaria, anaemia, diarrhoea, severe malnutrition, tuberculosis and other factors. Almost 60 percent of deaths among children under-five are preventable. Some of the same causes - malaria, diarrhoea, acute respiratory infections and measles - also account for most cases of child morbidity.

Malnutrition is a serious health problem in Ghana. The National Nutrition Survey (NNS, 1986) showed, using the U.S.-NCHS standard, that protein energy malnutrition (PEM) was high among children 0-60 months of age. It found, for example, that 51.5 percent of the age group were stunted (height-for-age below 90 percent of the standard), 40.3 percent were wasted (weight-for-height below 80 percent of the standard) and 8 percent were clinically classifiable as suffering from marasmus and kwashiorkor (that is, were severely malnourished). More recent surveys, however, suggest a notable improvement in nutritional status. An analysis by Alderman (1991), based on data from the GLSS (1989) and using the same standards as the NNS, found that, among children under five years of age, 19.6 percent were stunted and 5.1 percent were wasted. Using an alternative measure of nutritional status based on the same data but using a cut-off of two standard deviations below the U.S.-NCHS reference median, Alderman (ibid) found that among the under-five age group, 31 percent were stunted (below the reference median for height-for-age) and 7.9 percent were wasted (below the reference median for weight-for-height).

Other nutritional deficiencies in infants and children include nutritional anaemia which is aggravated by malaria, other infections and intestinal worm infestations. Vitamin A deficiency/xerophthalmia is also prevalent in the northern part of the country. In addition, the NNS (1986) found 10.7 percent of the population surveyed in the Upper Regions to be suffering from goitre, which is a manifestation of iodine deficiency disorder (IDD). Estimates reported by the World Bank (1989a) suggest that goitre may affect up to a third of the population in parts of the Northern and Ashanti Regions.

Relatively few children in Ghana have access to pre-school education. Nationally, less than 10 percent of the eligible age group (under 6) are enroled in pre-schools (communication from the MOE, 1992). A survey on pre-school services in Ghana (GNCC, 1984) found that the quality of physical infrastructure and instruction as well as the availability of necessary materials was grossly inadequate. To take a case in point, about 90 percent of the staff in pre-school units did not have proper academic qualifications.

According to the Ministry of Education (MOE, 1992), the gross enrolment ratio in primary schools was 82.5 percent in 1990 compared to 80.5 percent in 1988. Earlier data from the Ghana Living Standards Survey (GLSS, 1989), however, show that the net enrolment rate was about 67 percent in 1988-89 (that is, enrolment among the relevant age group, 6-11 years). This situation looks particularly problematic when drop-out rates are taken into account. Among the cohort entering primary school in 1978/79, the rate of "wastage", defined as the proportion of first year enrolment which had dropped out by the final year, was 27 percent and 36 percent for boys and girls, respectively. More recent data from the MOE (PBME Division, 1988/89) are alarming because they suggest an increase in the rate of "wastage" to 36 percent and 46 percent for boys and girls, respectively. There are also disturbing gender and spatial disparities in access to education. While girls account for almost half of total enrolment in primary schools located in Greater Accra Region, the figure is only 33 percent in the Northern Region.

The child in the Ghanaian family and society is affected by many factors. Rapid socio-economic changes notwithstanding, the extended family remains an important influence on the development of children. Another influential group in urban areas are maidservants or househelp. Certain cultural and social ceremonies and rites are also an important part of a child's upbringing in Ghana such as the ceremony of outdooring at

which a week-old child is publicly and ritually introduced into the family unit as well as society. Puberty rites are common among some ethnic groups but are mostly practised in rural areas. Traditionally, social upbringing proceeds along gender lines which clearly demarcate the respective responsibilities of males and females.

There are a significant number of children in especially difficult situations in Ghana. Ghanaian social systems have in-built structures through which members of the extended family are cared for, especially in times of need, such as **children who are orphaned or abandoned.** Nevertheless, as a result of socio-economic changes such as increased urbanisation, families are being forced to move away from the old securities of the extended family system and rely to a greater extent on institutional care.

Recent estimates from the DSW suggest that the incidence of **physical disability** was 10 per 100,000 population in 1991 (communication from the DSW, 1992). There is undoubtedly a pressing need to change social and individual attitudes which encourage a sense of helplessness and futility among disabled children. Limited assistance, targeted mostly to the physically disabled, is available from several voluntary organisations as well as the DSW. The tragedy is that physical disability, at least, can be largely prevented through cost-effective interventions.

Teenage pregnancies have become a serious issue in the country. Although reliable survey data are unavailable, anecdotal evidence seems to support the view that a significant number of young girls (including those under the age of 15) are becoming mothers. A major area of concern is the large number of unwanted pregnancies and related recourse to induced abortions. Moreover, this phenomenon may lead to a number of family and social difficulties. Another source of problems for girls is the practice of **female circumcision.** Studies conducted by Kadri (unpublished, 1986) and Twumasi (1988) have reported the practice in the Northern and Upper Regions and in Northern migrant settlement areas in Accra. Medical evidence shows that female circumcision complicates child birth and increases the risk of maternal death.

In Ghana, the term **"child labour"** applies by law to children below 16 years of age, under the following conditions: if the work is preventing the child from attending school and acquiring relevant skills for adult roles and responsibilities; if the child is exposed to danger; if the work causes harm to the child in whatever form; and if there is wilful and deliberate exploitation of the child. In a poor developing society like Ghana, however, children are often regarded as an economic asset and as security for old age. To a significant extent, therefore, "child labour" cannot be eliminated. In fact, it can also serve a useful socialisation function. Nevertheless, socialisation may camouflage or degenerate into exploitation, for instance, when children are engaged as maid servants, hawkers, cart-pushers and carriers at construction sites.

There is a general lack of reliable information on the extent of **child migration.** The problem is built into the social and economic norms of the country. It is not considered wrong, for example, that a 12 or 14 year old boy should leave the village for the city to look for work. Under these and other trying circumstances, children may also become the victims of **drug abuse** which has the potential for becoming a very serious social problem, especially among the under 18 year olds. The most common phenomenon is addiction to tobacco, marijuana, cocaine and heroin. In addition, there is abuse of common drugs in the treatment of child illnesses.

Although studies on **child delinquency** have not been made, observations suggest that the most affected groups include school drop-outs, those from broken homes and orphans. Delinquency may take various forms such as petty theft, violent behaviour towards elders, assault and general misdemeanour. Recently, however, there have been cases of drug trafficking. There may also be a relationship between the incidence of delinquent behaviour and the presence of increasing numbers of children of school-going age on the street and in other public places during school hours.

Ghana has a number of **laws** which deal with some of the problems discussed above. Nevertheless, while these legal provisions contain elements which are convergent with the United Nations Convention on the Rights of the Child, there is considerable scope for improvement, for instance, in establishing a single definition for a child and in combating some negative cultural and social practices.

The Situation of Women

The maternal mortality rate (MMR) was estimated to be 5-10 per 1000 live births in the mid-1970s. Since then, no validated community-based data has been collected to provide an up-to-date figure for the MMR. The immediate causes of maternal death can be divided into two categories, direct and indirect. A study by Antwi et. al. (unpublished, 1989), using hospital-based data, found that the leading direct cause of death was haemorrhage, of which post-partum haemorrhage was the main contributing factor. This was followed by septicemia and pregnancy-related hypertensive diseases. It is noteworthy that all these three direct causes, which account for 42 percent of maternal deaths, are, to a large extent, preventable.

The causes of maternal morbidity may be conveniently grouped under pregnancy-related complications and water-related/poor environmental sanitation diseases which affect the population generally. To these can be added malnutrition resulting in anaemia and sexually transmitted diseases such as gonorrhoea, syphilis, HIV seropositivity and AIDS (World Bank, 1989a).

Malnutrition among women is a major health problem, especially during pregnancy. A survey (Orraca-Tetteh, et. al., 1976) in Baafi, located in the Eastern Region, showed that pregnant women were meeting only 75 percent and 60 percent of their recommended caloric and protein intake, respectively. Micro-nutrient deficiencies are another common problem among women in Ghana. The most prevalent is iron-deficiency anaemia although vitamin A deficiency is also severe (but more concentrated in the three northern regions). Goitre, caused by iodine deficiency, is estimated to be a significant problem in parts of the Northern and Ashanti Regions (World Bank, 1989a). It is also believed to be prevalent in other parts of the country.

With regard to the educational status of women, the literacy rate of the population 9 years and over is currently estimated to be 42 percent for males compared to only 23 percent for females (GLSS, 1989). Literacy rates are generally high for both sexes between 15-34 years of age but fall rapidly for women in succeeding age groups. Rural-urban differences exist for all age groups.

As regards the position of a woman in the family, it is often dependent on whether she is married, single or widowed and young or old. She is valued because of both her productive and reproductive abilities. Even where women are heads of household, they do not always enjoy the same authority as men and may have to refer issues relating to children to male kin. The GLSS (1989) has shown that 29 percent of households in Ghana are headed by females. The proportion of female-headed households is highest in urban areas excluding Accra (32.9 percent) but in both rural and urban societies, the phenomenon may be on the increase. Most Ghanaian women have either been married at one time or another or live in consensual unions (GDHS, 1989). The average Ghanaian woman can also expect to bear 6.4 children during her reproductive years (GDHS, 1989), a slight decrease from the 6.7 children recorded by the Ghana Fertility Survey (GFS, 1979).

As for the economic role of women, farming, particularly food production, is the single most important occupation for them in rural areas. Women are also actively involved in agro-based industries such as gari-processing, palm oil and sheanut extraction and fish smoking. Other small-scale industries include pottery-making and handicrafts production. A small proportion of rural women engage in trading. In urban areas, access to the formal job market is quite restricted for women as they do not possess the requirements for entry such as good educational qualifications and skills. Early marriages and teenage pregnancies also deprive young women of opportunities to enter and survive in the labour market. Hence, the informal sector constitutes the most important source of employment for the majority of working urban women, in areas like trading, small-scale and cottage industries.

Underlying Causes

There are several underlying causes of the present situation of children and women in Ghana. These include, inter alia:

- The incidence and persistence of poverty. Although real GDP per capita increased by more than 15 percent between 1984-90 (Alderman, 1991), there are still questions about the extent of success in translating this gain into substantial growth in household real incomes to satisfy basic needs. Although recent analysis from the World Bank (1991) suggests that trends in agriculture have contributed to an increase in rural incomes since 1984-85, there are doubts about its positive impact on rural poverty, given the economic structure and distribution of income in Ghana. For example, 70 percent of the population is located in rural areas (GSS, 1984) and is predominantly engaged in subsistence food production (MOA, 1986). Meanwhile, data from the GLSS (1989) reveal marked inequalities in the distribution of income by type of productive activity, rural or urban residence and regional location (World Bank, 1989c). Farmers are the worst-off group, with cocoa farmers doing somewhat better than food producers. Approximately 60 percent of the poorest tenth of the population are located in Northern Ghana with the other 40 percent split evenly between the Coastal and Forest Zones. Thus, Alderman (1991) states that the estimated effect of increased producer prices for cocoa, which have played a key role in shifting sectoral and inter-sectoral terms-of-trade, would amount to only 2.8 percent of the total income of the extreme poor. Furthermore, since northern Ghana does not grow cocoa, it appears to have benefited only indirectly, if at all, from higher cocoa prices.

- Food insecurity. Despite recent improvements in some social and economic indicators, significant numbers of Ghanaians remain food insecure: small-scale subsistence food producers, migrant labourers and petty traders/producers in the informal sector, especially in urban areas. In terms of gender, women are by far the more vulnerable group, a situation which negatively affects children as well.

  While recent increases in food production and the downward trend in food prices are encouraging developments, there are still a number of important obstacles to ensuring adequate food availability. These include, inter alia, the relatively low productivity of farmers; dependence on rain-fed agriculture; the poor, though improving, condition of the transport infrastructure; high post-harvest losses and insufficient storage capacity; and weaknesses in the delivery of agricultural services.

  The impact of economic recovery on the entitlements of vulnerable groups also remains unclear. It appears as if net purchasers of food, especially those in urban areas, have benefited from increases in food production and a decline in prices. In rural areas, farmers engaged in cash crop production, principally cocoa, have benefited from favourable terms of trade vis a vis food crops, as indicated in the section above. In addition, the minority of farmers producing food for the market may have gained, despite falling prices, because of increases in yields. On the other hand, it is possible to assert that small-scale subsistence food producers, or the majority of the rural and farming population, have yet to participate fully in the process of economic recovery.

- Limited physical accessibility to social and environmental services of a minimum quality such as basic education, primary health care, safe water and sanitary means of excreta disposal and adequate shelter. The coverage of health services, for example, is only 45 percent in rural areas compared to 92 percent in urban areas, yielding an overall coverage rate of 60 percent nationally. The attainment of improved access as well as quality is constrained by structural problems such as the overcentralization of operations; limited community participation; weak planning, monitoring and evaluation; poor human resource management; and disparities in the distribution of facilities and personnel.

- Insufficient attention in policies and programmes to the pivotal role of women in social and economic development. Women are not only heading a large number of households but are also critical in the operation and maintenance of social services as well as in food production and processing and trading. Yet, numerous obstacles still remain to be overcome in recognising and building upon the contributions

of women. These include the gender insensitivity of policy and programme formulation and monitoring; inappropriate regard for the institutional structures needed to reach women effectively; and ingrained and negative social and cultural attitudes and behaviour towards women.

A rapidly growing population which increases dependency on productive members of households, strains the capacity of public and private institutions to provide basic social services and adds to the problem of food insecurity. It also dissipates the income-enhancing impact of economic growth.

Ghana's population is currently expanding at an observed annual rate of 2.6 percent though estimates suggest that the growth rate may now be 3.1 percent per annum (Ghana Statistical Service). As for the future, the World Bank (1989a) projects a growth rate of 3 percent per annum for the period 1987-2000. This pattern of growth has yielded a population structure in which almost half the people are under 15 years of age.

- The vulnerability of the Ghanaian economy to internal and external macroeconomic instability reflected in a high inflation rate, reversals in the terms-of-trade of primary exports, and an uncertain aid and investment climate. To take a case in point, because of Ghana's dependence on the taxation of primary commodity exports, adverse movements in the terms-of-trade directly influence the level and stability of public expenditure from year-to-year.

Chapter Two - The Broad Framework for Action: A Human Development Strategy for Ghana

"Human development" is a concept which defines both the purpose and process of development. Thus, the goal of human development is to enlarge "....people's choices....at all levels of development, the three essential ones are for people to lead a long and healthy life, to acquire knowledge and to have access to the resources needed for a decent standard of living....Additional choices....range from political, economic and social freedom to opportunities for being creative and productive, and enjoying personal self-respect and guaranteed human rights," (UNDP, 1990). The process of human development, therefore, entails both "....the formation of human capabilities....and the use people make of their acquired capabilities," (ibid).

The Human Development Strategy for Ghana (HDS) has been prepared in response to several challenges including a need to change the logic of development policy-making, to supplant a preoccupation with means (for example, economic growth) with a concern with ends (that is, human development); the importance of resolving problems of disparity; the necessity of addressing environmental concerns; and the task of building a transparent, accountable and efficient system of public administration.

The HDS has a number of multi-sectoral goals which define thematic areas for intervention and action. Some of the key goals touch on social issues, for instance, educational achievement, health for all, nutrition, food security, safe water supply and sanitation and housing. An integrated set of strategies are proposed to achieve these goals. They focus on strengthening the capacity of public institutions, improving coordination among the various organisations engaged in development activities, continuing the policy of decentralisation, promoting increased investment in social and economic infrastructure and achieving greater community participation.

There is a strongly symbiotic relationship between the HDS and the NPA. Three dimensions of this relationship are particularly noteworthy. Firstly, the two initiatives share common goals, concerns and strategies, whether general or sector-specific. Secondly, the NPA may be seen as the concrete expression of the social aspects of the HDS. Finally, past experience in Ghana and abroad has clearly demonstrated that isolated programmes and projects cannot be effective nor can their long-run impact be sustained without a supportive framework of development policies, represented in this case by the HDS.

Chapter Three - The Outline of a Better Future for the Ghanaian Child: Goals for the Year 2002

The major goals of the Programme of Action are as follows:

a. Reduction of the Infant and Under Five Mortality Rates (IMR/U5MR) by 35 percent, from 77 to 50 per 1000 live births and 155 to 100 per 1000 births, respectively.
b. Reduction of the maternal mortality rate by a third.
c. Reduction of severe and moderate malnutrition among children under 5 years of age by 50 percent.
d. Universal access to basic education and completion of primary education by at least 80 percent of children in the relevant age-group (6-11 years).
e. Reduction of the female illiteracy rate (among those 15 years of age and above) by 50 percent.
f. Increase in the coverage of safe water supply to 90 percent of the rural population (by the year 2010).
g. Increase in the coverage of facilities for sanitary means of excreta disposal to 90 percent of the rural population (by the year 2010).
h. Reduction in the proportion of children in especially difficult situations.
i. Widespread acceptance and observance of the Convention on the Rights of the Child.

Chapter Four - Sectoral Programmes of Action

Population, Health and Nutrition (PHN)

The principal objectives of the PHN Programme are to reduce the IMR attributable to preventable causes by 70 percent; reduce the CMR (1-4 years of age) attributable to preventable causes by 60 percent; reduce the MMR attributable to preventable causes by 50 percent; reduce the incidence of teenage pregnancy by 50 percent; reduce the rate of low birthweight (2.5 kg or less) from 24 to 10 percent; reduce the incidence of immunisable diseases by 70 percent; eradicate poliomyelitis; and eradicate dracunculiasis/guineaworm disease (by 1993). Other principal objectives are to reduce the prevalence of protein energy malnutrition (PEM) among children under five years of age by half; reduce the prevalence of micronutrient deficiencies among children under eighteen years of age and women of child-bearing age (15-44 years); reduce the prevalence of anaemia among pregnant women by 50 percent; reduce the TFR by 10 percent; increase awareness on critical health, nutrition and family planning issues among at least two-thirds of the population; and establish a fully operational and decentralised district health system.

The strategies for achieving these objectives would include the following: accelerated restructuring of the governmental health system; integrated planning and delivery of services within a decentralised, district level health care system; expanded physical access to health facilities; improved approaches for dealing with major health and nutrition problems; strengthened and reorientated support services for decentralised operations; increased efficiency in resource allocation and use; enhanced sustainability of PHN services; and expanded utilisation of services.

Specific programme activities would encompass:

- The launching of a District Capacity-Building Initiative;
- Construction of district and sub-district level health facilities and increased outreach from fixed facilities;
- Development of a framework of services for the district, sub-district and community levels (including school health services);
- Identification of effective strategies for dealing with major health and nutrition problems such as malaria, AIDS, micronutrient deficiencies and teenage pregnancy;
- Continued development of support functions (policy analysis, planning and budgeting, human resource development and management, logistics and supply and inter-sectoral coordination);
- Increased mobilisation of resources from domestic and external sources (service users, communities, districts, central government and donors);

- Strengthened sustainability through the expansion of community-based health care, sub-contracting of service provision to NGOs, greater participation of the private sector, the development of a national health insurance system and increased emphasis on traditional medicine; and, finally,
- Intensified IE&C programmes.

The PHN Programme would be managed by the MOH. It is estimated to cost about $241 million in its first five years (1993-97), composed of $233 million in capital and $8 million in recurrent expenditures.

Education

The principal objectives of the Education Programme are to increase the enrolment rate in pre-schools from about 10 percent to 30 percent; increase the net enrolment ratio in primary schools from 65 to 98 percent; and increase the number of adult females enroled in non-formal education programmes by 27 percent from 180,000 per annum to 230,000 per annum. Supporting objectives include the elimination of gender disparities in primary education and a reduction in the rate of "wastage" by 50 percent.

The proposed programme strategies would be consistent with and complementary to the on-going education reform programme. They would entail increased emphasis on pre-school education; expanded physical access to primary schools; continued improvements in the quality of basic education; strengthened links between schooling and employment; focused efforts for particularly disadvantaged groups; and improved management of education services. Programme activities would include:

- The adoption of a policy framework for pre-school education, strengthening of the Pre-School Unit in the GES, construction of an increased number of pre-schools, revised and expanded training programmes for pre-school teachers and a review and revision of the curriculum;
- The development and implementation of a financing scheme for the rehabilitation and construction of primary schools, modelled on the PAMSCAD Community Initiative Projects;
- An expansion in the textbook replenishment fund of the MOE coupled with the elaboration of a scheme involving the Government, NGOs and the private sector, to equip JSS workshops; improved teacher training and supervision complemented with incentives for better teacher performance;
- The development of closer links between farmers/fishermen, the agricultural extension service and schools; a review of rules and regulations governing apprenticeship; a restructuring of the more than 40 governmental technical institutes and vocational training institutes to increase their intake of JSS graduates; support for craftsmen participating in apprenticeship programmes as well as the "graduates" of these programmes;
- The implementation of small-scale projects designed to demonstrate effective ways of reaching particularly disadvantaged groups such as girls, students of Islamic schools and shepherds; and
- Improved management of education services through support for the successful decentralisation of the MOE's operations and the development of more attractive conditions of service for teachers and principals.

The Education Programme would be principally managed by the MOE. It is estimated to cost $114 million in its first five years (1993-97), consisting of $77 million in capital and US$37 million in recurrent expenditures.

Water Supply and Sanitation (WS/S)

The principal objectives of the WS/S Programme are to: increase the coverage of safe water supply to 90 percent of the rural population by the year 2010 (coverage in urban areas would meet or exceed the rural target by the year 2010); increase the coverage of facilities for sanitary means of excreta disposal to 90 percent of the rural population by the year 2010; ensure that an increasing proportion of households have waste water and storm water disposal facilities of an acceptable standard; ensure that an increasing proportion of households and communities have an adequate system for the collection and disposal of refuse; raise awareness among the population on proper hygiene and environmental sanitation; and establish "....within the private sector in all regions the capacity to construct low-cost latrines and hand dug wells and to maintain manual and mechanized pumps," (MWH, 1991).

A linked set of strategies, as follows, would help to achieve programme objectives: increased physical access to safe drinking water and sanitation facilities; enhanced sustainability of WS/S services; development and diffusion of low-cost and appropriate technologies; intensified mobilisation and education of the population; and improved coordination among funding and implementing agencies.

Programme activities would embrace:

- Finalisation, adoption and launching of the National Rural Water Supply and Sanitation (RWS/S) Programme;
- Clarification of the institutional framework for the WS/S sector, especially the internal organisation of the Ghana Water and Sewerage Corporation (GWSC);
- Strengthening of institutional capacity (information systems, human resources and private sector development);
- Preparation of a sustainable financing package based on cost sharing and cost recovery;
- The elaboration and launching of a national technology development and promotion programme for RWS/S emphasising simple, low-cost and socially appropriate technologies based on indigenous skills and manufacturing capabilities;
- Construction/rehabilitation of WS/S facilities;
- Intensified IE&C activities focused on creating demand for WS/S facilities and improving awareness on environmental sanitation and hygiene practices; and
- The formation of coordinating fora at the regional and district levels.

The WS/S Programme would be primarily managed by the Ministry of Works and Housing through the GWSC. The estimated cost of the Programme is $155 million for the first five years of implementation (1993-97). The cost figure is composed of $144 million in capital and $11 million in recurrent expenditures.

Children in Especially Difficult Situations (CEDS)

The principal objectives of the programme are to improve knowledge and awareness of the causes and dimensions of the problems characterising CEDS; integrate the disabled into the social, economic and cultural life of their communities; reduce the proportion of children on the street; and significantly improve protection for working children.

Programme strategies include an expansion in the operational capabilities of the DSW; improved data collection and analysis on CEDS; a clarification and strengthening of the legal framework for child rights; improved targeting and design of programmes; increased access to specialised facilities; and increased public awareness on CEDS. These strategies will be implemented through the following activities:

- Capacity-building of the DSW;
- Research (including surveys and studies) on disability, teenage pregnancy, working children and children on the street;
- Development of proposals, for consideration by the Government and Parliament, on more effectively incorporating child rights into Ghanaian law;
- The development of targeted programmes using innovative design to reach affected children, for example, community-based rehabilitation of the disabled and the establishment of literacy-cum-job training centres in or near places where the phenomenon of children on the street is most acute;
- The rehabilitation of existing specialised facilities (rehabilitation centres and children's homes) followed by expansion in the size and number of facilities, to provide a cluster of specialised services for the disabled, delinquent and orphaned in each of the three major zones of Ghana - Northern, Central and Southern; and
- Intensified advocacy on CEDS, using results from research activities.

The CEDS Programme would be managed by the DSW. It is estimated to cost $1 million in the first five years of implementation (1993-97), mostly for capital expenditures.

Advocacy

The principal objectives of the programme are to raise public awareness on the condition of children and women in Ghana; increase public awareness on the provisions of the Constitution relating to Children's and Women's Rights as well as the contents of the Convention on the Rights of the Child; expand demand for the utilisation of basic services; and improve the institutional capacity and performance of key public institutions responsible for advocacy on behalf of children and women.

Advocacy objectives will be pursued through strategies focusing on the capacity-building of key public institutions; sustained mobilisation of allies; increased availability of "software" for advocacy and IE&C; and greater integration of IE&C programmes. These strategies will be translated into the following activities:

- Institutional strengthening of the GNCC and NCWD to improve their technical capacity and operational viability and extend their reach into the districts;
- The organisation of annual meetings at all levels of administration to review the status of children, assess actions undertaken on their behalf and identify additional steps required, to precede the yearly budget preparation process;
- Increased production of "software" including a biennial State of Ghana's Children Report, posters, leaflets, radio messages and videos; and
- The creation of fora at all levels of administration, led by the GNCC, to achieve better coordination of IE&C activities concerned with child survival and development.

The principal responsibility for managing the Advocacy Programme would rest with the GNCC. It is estimated that the programme would cost $2.6 million in its first five years (1993-97) composed of $1.3 million in capital and $1.3 million in recurrent expenditures.

Chapter Five - Financing the National Programme of Action

Introduction

The first five years (1993-97) of the decade-long NPA (1993-2002) would cost $514 million in 1992 prices. This would consist of $457 million and $57 million in capital and recurrent expenditures, respectively. Of these costs, $180 million is already funded by the GOG and donors as part of on-going and planned programmes. The resource gap would, therefore, amount to $334 million composed of $277 million in capital and $57 million in recurrent expenditures.

A Scenario for Domestic Resource Mobilisation

The Government's ability to close the resource gap would hinge on the performance of the economy, measured by the growth rate of real gross domestic product (GDP). The target set in the most recent Policy Framework Paper/PFP (1992-94) is for an average annual growth rate of about 5.5 percent which compares with an achieved annual rate of approximately 5 percent since the inception of the ERP in 1983.

In order to assess the potential contribution of the GOG, an analysis has been made, based on the conservative assumption of an average annual growth rate of real GDP of 4 percent during 1993-97. This lower figure has been selected for two related reasons: first, to develop a credible measure for testing the financial feasibility of the NPA; and, second, to build into the financing scenario the possibility of internal and external shocks. The projections show that cumulative incremental GDP over the period would amount to $3,640 million.

The feasible volume of contributions from the GOG has been gauged using the average allocations for health, basic education, water and sanitation and other children's/women's programmes (CEDS/Advocacy) in public expenditure during 1985-90, expressed as a percentage of GDP, that is, 1.2, 2.2, 0.05 and 0.01, respectively. In absolute amounts, these proportions translate into additional funding of $43.7 million for

health, $80.1 million for basic education, $1.82 million for water and sanitation and $0.36 million for other children's/women's programmes. Thus, about $126 million could be made available by the GOG without raising new taxes or cutting expenditures in non-social areas.

Another source of domestic financing would be communities. The latter have a long tradition of contributing to the development of their areas through levies on cocoa, coffee and other cash crops or a flat contribution per adult. Communities are presently contributing to the construction of schools, clinics, wells and other social and economic infrastructure. Consideration of these issues as well as the scale of proposed activities indicates that approximately $61 million would be generated by communities to finance the NPA.

Resources would also be mobilised through cost recovery. One of the key elements of the ERP has been an effort to ensure the sustainability of public services as well as ensure their efficient use through cost reduction and cost recovery. It is, therefore, anticipated that apart from direct community contributions, increases in revenues from user fees would accompany the expansion in infrastructure and services proposed in the NPA. Estimates suggest that at least $13 million could be generated in this manner during 1993-97.

Thus, domestic resource mobilisation from the GOG and communities and through cost recovery would be expected to generate $200 million towards closing the resource gap of US$334 million or almost 60 percent of the additional funding required. Within the Government's contribution, capital costs would absorb $81 million and recurrent costs the remaining $45 million. In contrast, all of the communities' contribution would be used to fund capital costs.

A Challenge for International Cooperation

Domestic resource mobilisation would leave a residual gap of $134 million which would necessitate a search for external sources of financing. To put this amount into perspective, the level of commitments from donors has averaged about $800 million per annum since 1988. Assuming a continuation of this trend during 1993-97, total donor commitments over the period would amount to $4 billion. Viewed in this context, the total cost of the NPA, the total resource gap and the gap remaining after domestic resource mobilisation would constitute 13 percent, 8.3 percent and 3.3 percent, respectively, of total commitments. These aggregate figures can, however, overstate the volume of external assistance potentially available for the types of programmes proposed in the NPA. Data from the UNDP (1991b, 1991c) suggest that only 13-15 percent of aid disbursements since the launching of the ERP have been directed towards the social sectors. Moreover, the latter numbers refer to global amounts channelled towards social development and, therefore, do not necessarily reflect the shares allocated to areas of concern in the NPA, for example, primary health care and basic education - if global patterns are any guide (UNDP, 1992), then the proportion of aid spent on these areas may be found to be surprisingly small.

External funding might also be mobilised through debt relief. The precedent for such an approach has already been set in the case of Ghana. The World Bank (1991) estimates that "savings" from debt cancellation or conversion (into grants) by some leading donors amounted to $30 million in 1990 and would remain at that level per annum, on average, during 1991-93. The most recent data (World Bank, 1991a) suggest that there is still some scope for further relief: in 1990, total debt service (principal and interest payments) on long-term bilateral debt amounted to $52 million.

Additional donor assistance could be channelled in innovative ways. For example, savings in local currency from debt relief can be earmarked for the NPA in the form of a Solidarity Fund which would disburse small grants to stimulate and sustain community initiated and managed activities. Another option would be to establish an education endowment to fund scholarships for girls and promote innovative programmes to redress gender imbalances in educational achievement in particularly disadvantaged areas. It would also be possible to establish a Social Stabilisation Fund (SSF) which would make funds available to maintain a minimum level of social expenditure during periods of internal or external shocks and provide an additional pool of resources for social investment during "normal" years.

Chapter Six - Maintaining the Momentum: Leadership for Action

Institutionalising a Commitment to Ghana's Children

The concerns of children and the promises which have been made to them will require the political leadership, public sector managers, NGOs and the general public to become actively engaged in the implementation and monitoring of the Programme of Action, to ensure that these issues become a permanent item on the country's agenda. This desirable outcome can be facilitated through appropriate institutional arrangements.

The proposed institutional framework, articulated by the level of administration or participation, envisages a high level of community involvement. Communities would establish the basis for joint action with "external" partners, manage some services and monitor the outcome of activities. The institutional framework also focuses on the progressive strengthening of districts as the level at which social services will increasingly be managed and monitored. The key institution in the Districts would be the Assembly assisted by the District Planning and Budgeting Unit (DPBU) and the offices of the decentralised departments. The principal task at the regional level would be to mediate between national and district level perceptions of needs and priorities. The institutional focus for this activity would be the Regional Coordinating Council (RCC). Within the RCC, a Sub-Committee on Children, chaired by the Regional Secretary, would provide leadership on the relevant issues. The RCC would be assisted in its work by the line departments represented at that level (including the regional representatives of the GNCC and NCWD) as well as the Regional Planning and Coordinating Units (RPCUs), when they are established.

At the national level, a Sub-Committee of the Cabinet reporting to the Head of State would be established. It would include Secretaries of State from the NDPC, MFEP and selected sectoral ministries/agencies. Alternatively, the mandate of an existing Sub-Committee could be expanded. The main purpose would be to provide a high level political forum for the follow-up to the World Summit. The Sub-Committee would be supported by a group chaired by the Cabinet Secretariat and including representatives from the GNCC, NCWD, NDPC and MFEP. The activities of the Cabinet would be complemented by the future Parliament through one of its Standing Committees or a special Sub-Committee specifically established to address the concerns of children. Finally, whereas the Cabinet and Parliament would set the broad parameters for action, the specifics of implementation and monitoring at the national level would remain the responsibility of key coordinating, financing and sectoral ministries as well as the relevant cross-sectoral Commissions.

Developing Institutionalised Processes

A series of activities would be pursued on a regular basis to institutionalise a continuous process of policy supervision, monitoring and assessment of progress. At the grassroots, communities would be supported, through improved information dissemination and advocacy, to keep children's concerns high on their agenda. At the district level, an annual meeting of both the Executive Committee and Social Sector Sub-Committee of the Assembly would be dedicated to an examination of children's issues (including their changing status), monitoring of child-related development activities and decision-making with regard to support from the district budget. The outcome of discussions at the district level would be communicated to the regional level as an input into the RCC's own annual meeting dedicated to children.

At the national level, there would be semi-annual meetings of the Cabinet Sub-Committee concerned with tasks similar to those performed at other levels. This gathering would, in addition, concern itself with strategic issues, especially those related to policy direction and budgetary allocations. The outcome of these meetings would be presented to and discussed by the full Cabinet and subsequently submitted to the Head of State and Parliament in the form of an annual report on the Programme of Action. The national meetings as well as those at the regional and district levels would be timed to precede the annual budget preparation process.

Generating Data for Successful Monitoring

The effectiveness of the institutional framework and process proposed above would depend, to a significant extent, on the availability and timeliness of information on relevant monitoring indicators. To be useful, this information would also have to be disaggregated to reveal and track the evolution of gender and spatial disparities. A considerable investment would, therefore, be made to incorporate these issues in regular and periodic monitoring and evaluation activities.

The NPA has been prepared using, to the extent possible, existing sources of information, to develop a baseline for establishing the overall and sectoral objectives as well as for assessing progress. In those cases in which there is conflicting, unreliable or outdated information on indicators, surveys would be commissioned between 1992-94 to close the gap. In fact, a number of initiatives are already underway or planned: a national survey on infant, child and maternal mortality is on-going and should be completed by the end of 1992; another national survey on child nutritional status is expected to be undertaken in 1993; and a second GDHS is being planned for 1993.

As for on-going monitoring of input and output indicators, the task will be performed by the responsible sectoral ministry/agency as part of its regular information gathering activities. Considerable emphasis has also been placed on the integration of communities within the regular sectoral monitoring systems. With regard to the assessment of impact, the NPA proposes that a National Social Survey based on a consolidated version of the GDHS/GLSS be commissioned every five years (1996-97, 2001-2). This would not be an expensive activity since the capacity of the Statistical Service has already been strengthened for this purpose and nationally representative population samples would have been developed for on-going surveys.

The monitoring data generated from the system proposed above would serve as an input into the annual meetings described earlier. They would also provide the information for a mid-term evaluation of the NPA in the last quarter of 1997. Furthermore, the impact of the data would be fully exploited through the publication of a biennial Report on the State of Ghanaian Children. The first issue would be published in 1994. An updated GOG/UNICEF Situation Analysis of Children and Women in Ghana would also be published in 1995.

PRIORITY PLAN OF ACTION FOR CHILDREN: 1993-97

I. INTRODUCTION

The National Programme of Action has been prepared in response to the broad mandate of the World Summit *Declaration* and *Plan of Action*. The NPA is also a concrete expression of the social aspects of the Human Development Strategy (HDS) for Ghana which argues that the priority concerns of development policy must be "....related to the strengthening of prospects of sheer survival and putting a halt to further deterioration in levels of deprivation....to put a "safety net" in place, especially for vulnerable and disadvantaged population groups," (NDPC, 1991). Interventions will, thus, "....represent "bottom line" actions designed to provide minimum conditions for achievement of significant, medium- and long-term, broad-based....improvements," (ibid). Reflecting these concerns, the Programme incorporates a ten-year planning horizon designed to provide sufficient time to tackle at least some of the underlying social and economic threats to the wellbeing of children. Both the comprehensiveness of the mandate and the duration of the NPA are a product of the growing realisation that the needs of children cannot be isolated from the wider environment in which they are born and brought up. While children do have particular needs which require a focused response, any attempt to deal with the root problems, such as poverty or inadequate social services, will necessarily address the concerns of, and affect, a wider population.

In view of these considerations, the NPA deals with a wide range of issues which directly or indirectly impinge on the condition of children. For instance, it touches upon the issues of overall development policy, seen from the perspective of human development. The argument is made, for example, that one of the most effective ways of sustainably improving the condition of children would be to achieve well-distributed growth in the economy, enabling incomes to rise appreciably and for greater resources to be directed towards social development.

To take another case in point, the sectoral programmes of action in the NPA have been deliberately concentrated on building up social infrastructure and improving the quality and range of social services, within the constraints of resource availability. Past experience has clearly demonstrated that it is only possible to realise temporary gains in child welfare if underlying weaknesses in social infrastructure and services are not addressed. An initiative such as the NPA must, as a consequence, ensure that ad hoc, short-term and palliative measures do not substitute for a longer-term concern with underlying or structural causes. It would, therefore, be correct to say that the NPA has been consciously designed as a long-term social investment programme, albeit with a particular focus on children. For example, an investment which significantly increases access to water and sanitation facilities will be of immense benefit to children but it will also serve the needs of the wider population. Similarly, interventions designed to reduce maternal mortality and improve women's health and educational achievement will, in the first instance, directly benefit many adult women but indirectly make an important contribution to better child care practices.

Nevertheless, even though there is a sound rationale for the broad focus of the NPA, it is appreciated that simultaneous movement on all fronts may be a difficult, though not impossible, feat to accomplish, at least during the initial years of the Programme. As a result, an effort has been made to identify a set of priority objectives, strategies and actions for the first five years (1993-97), in case broader progress proves unfeasible. The selection criteria and the resulting Priority Plan are presented in sections II and III below.

II. SELECTING THE PRIORITIES

The priorities have been selected on the basis of the following criteria:

- Responsiveness to the most pressing needs of children. The situation analysis suggests that the most basic considerations must be to significantly improve the child's chances of survival and growth during the first five years of life, establish the minimum conditions for the acquisition of literacy and protect those children who are particularly vulnerable due to social, cultural or economic reasons. As a result, attention would be focused on dealing with the

immediate causes of child mortality and morbidity, raising enrolments in primary school while significantly improving retention, providing targeted assistance for CEDS and creating and enforcing a more favourable legal framework for child rights.

- Potential for complementing on-going and planned initiatives and programmes by closing gaps in analysis, infrastructure and services. Ghana's economic recovery over the last decade has restored and substantially improved the coverage and quality of social infrastructure and services as well as information on key social indicators. Nevertheless, there is still significant scope for improvement. For example, in the health sector, access to PHC, especially MCH services, has to be expanded considerably in rural areas; strengthened strategies to cope with child health problems need to be developed and implemented through an integrated service delivery structure instead of being dispersed through vertical programmes, as at present; and greater emphasis needs to be given to the development of community co-managed and co-financed services in order to bring a minimal level of health care as close as possible to children.

- Ability to capitalise on existing social infrastructure. While significant additional investment in social development will continue to be necessary in the future for both children and adults, it may be possible to achieve better results from past expenditures by, inter alia, improving efficiency through cost sharing, cost recovery and cost savings; raising productivity by means of training; expanding access by involving all potential service providers; and maximising capacity utilisation through increased awareness among the population.

III. THE PRIORITY PLAN OF ACTION: 1993-97

The following Priority Plan of Action for the first five years of the NPA (1993-97) is proposed, based on the criteria elaborated in section II.

Major Goals for the Well-Being of Ghanaian Children

a. Reduction of the Infant and Under-Five Mortality Rates (IMR/U5MR) by 17.5 percent to 63 per 1000 live births and 128 per 1000 live births, respectively.

b. Expansion in primary school enrolment to 80 percent of the relevant age group (6-11 years) and completion of primary school by at least 60 percent of this age group.

c. Reduction in the proportion of children in especially difficult situations.

c. Widespread acceptance and observance of the Convention on the Rights of the Child.

Sectoral Programmes of Action

Population, Health and Nutrition (PHN)

Principal Objectives

(a) Reduce the IMR attributable to preventable causes by 35 percent, from the current level of 48 percent to 31 percent;
(b) Reduce the Child Mortality Rate/CMR (1-4 years of age) attributable to preventable causes by 30 percent, from the current level of 64 percent to 42 percent;
(c) Reduce the incidence of teenage pregnancy by 50 percent;
(d) Reduce the rate of low birthweight (2.5 kg or less) from 24 percent to 17 percent;
(e) Reduce the incidence of immunisable diseases by 35 percent;
(f) Eradicate poliomyelitis;

(g) Reduce the prevalence of protein energy malnutrition (PEM) among children under five years of age by 25 percent (stunting, wasting, low weight-for-age); and

(h) Increase awareness on critical health, nutrition and family planning issues among at least two-thirds of the population.

Programme strategies would include integrated planning and delivery of services within a decentralised district/sub-district/community level health care system; increased physical access to PHN services; improved strategies for dealing with major health and nutrition problems affecting children; strengthened support services; increased efficiency in resource allocation and use; enhanced sustainability of PHN services; and expanded utilisation of services.

Programme activities would comprise the development of a framework of services for the district, sub-district and community levels (including school health services); construction of health centres; increased outreach from fixed facilities; identification of effective strategies for dealing with malaria, ARI, immunisable diseases, diarrhoeal diseases, PEM and teenage pregnancy; assessment of manpower requirements, development of appropriate training institutions and programmes and identification of feasible incentive schemes; increased mobilisation of resources from domestic and external sources (service users, communities, districts, central government and donors); expansion of community-based health care and sub-contracting of service provision to NGOs; and intensified IE&C programmes.

Education

Principal Objectives

(a) Reduce the rate of "wastage" in primary schools by 25 percent; and

(b) Decrease gender disparities in primary education.

Programme strategies would entail expanded physical access to primary schools; continued improvements in the quality of basic, especially primary, education; and focused efforts for particularly disadvantaged groups.

Programme activities would involve the development and implementation of a financing scheme for the rehabilitation and construction of primary schools; an expansion in the textbook replenishment fund of the MOE; improved teacher training, supervision and remuneration; and the implementation of small-scale projects designed to demonstrate effective ways of reaching particularly disadvantaged groups such as girls, students of Islamic schools and shepherds.

Water Supply and Sanitation (WS/S)

Principal Objectives

(a) Increase the coverage of safe water supply for the rural population by 20 percent of the targeted expansion to the year 2010;

(b) Increase the coverage of facilities for sanitary means of excreta disposal for the rural population by 20 percent of the targeted expansion to the year 2010; and

(c) Raise awareness among the population on proper hygiene and environmental sanitation.

Programme strategies would emphasise the timely completion and launching of the National RWS/S Programme involving, in particular, increased physical access to safe drinking water and sanitation facilities; enhanced sustainability of WS/S services; and intensified mobilisation and education of the population.

Programme activities would embrace the finalisation, adoption and launching of the National RWS/S Programme; strengthening of institutional capacity (human resources and private sector development); preparation of a sustainable financing package based on cost sharing and cost recovery; rehabilitation/ construction of water supply and sanitation facilities; and intensified IE&C activities focused on creating demand for WS/S facilities and improving awareness on environmental sanitation and hygiene practices.

***Children in Especially Difficult Situations* (CEDS)**

Principal Objectives

(a) Improve knowledge and awareness of the causes and dimensions of the problems characterising CEDS;
(b) Integrate the disabled into the social, economic and cultural life of their communities;
(c) Reduce the proportion of children on the street; and
(d) Significantly improve protection for working children.

Programme strategies would focus on an expansion in the operational capabilities of the DSW; improved data collection and analysis on CEDS; a clarification and strengthening of the legal framework for child rights; improved targeting and design of programmes; greater access to specialised facilities; and increased public awareness on CEDS.

Programme activities would include capacity-building of the DSW; research (including surveys and studies); development of proposals, for consideration by the Government and Parliament, on more effectively incorporating child rights in Ghanaian law; the launching of targeted programmes using innovative design to reach affected children; the rehabilitation of existing specialised facilities followed by an expansion in the size and number of facilities, to provide a cluster of specialised services in each of the major zones of the country; and intensified advocacy on CEDS, using results from research activities.

Advocacy

Principal Objectives

(a) Raise public awareness of the condition of children and women in Ghana;
(b) Increase public awareness on the provisions of the Constitution relating to Children's Rights as well as the contents of the Convention on the Rights of the Child;
(c) Expand demand for and utilisation of basic services; and
(d) Improve the institutional capacity and performance of key public institutions responsible for advocacy on behalf of children.

Programme strategies would embrace capacity-building of key public institutions; sustained mobilisation of allies; and increased availability of "software" for advocacy and IE&C.

Programme activities would entail the institutional strengthening of the GNCC to improve its technical capacity and operational viability and extend its reach into the districts; the organisation of annual meetings at all levels of administration to review the status of children, assess actions undertaken on their behalf and identify additional steps required, to precede the yearly budget preparation process; increased production of "software", especially a biennial State of Ghana's Children Report; and integration of the design and delivery of IE&C programmes within a strengthened social mobilisation structure.

Financing the Priority Plan of Action

The Priority Plan of Action would cost approximately $242 million composed of $189 million in capital and $53 million in recurrent expenditures. The sectoral breakdowns are as follows: PHN - $137 million capital, $3.6 million recurrent; Education - $30.5 million capital, $37.2 million recurrent; WS/S - $19 million capital, $11 million recurrent; CEDS - $1.028 million capital, $ 0.069 million recurrent; and Advocacy - $1.3 million capital and $1.3 million recurrent.

Of total costs, $148 million is already funded by the Government of Ghana and donors as part of on-going and planned interventions. The financing gap would, therefore, amount to $94 million, comprising $41 million in capital and $53 million in recurrent expenditures. In view of the possibilities for domestic resource mobilisation discussed earlier, it would be feasible to fund the entire Priority Plan locally.

INTRODUCTION

I. GLOBAL PERSPECTIVES ON DEVELOPMENT IN THE 1990s

A consensus has been emerging in the international community on the purpose and promotion of development in the 1990s. It is influenced, to a large extent, by the experiences of the 1980s which have been described as the "Lost Decade" for much of the Third World, especially sub-Saharan Africa.

The tremendous difficulties encountered during the 1980s, which are still present today, were the result of a combination of factors. On the one hand, a harsh external environment meant that many developing countries were faced with onerous debt servicing obligations as real interest rates increased, terms-of-trade worsened and export earnings declined. These adverse conditions were exacerbated, on the other hand, by major errors in domestic economic management exemplified by, inter alia, expansionary fiscal and monetary policies, administered pricing, an overvalued exchange rate, a protectionist trade regime and a proliferation of poorly managed state-owned enterprises (SOEs). The consequences were a persistent debt crisis and a slowing down or even reversal of economic and social development, particularly in sub-Saharan Africa, with children and women being among the worst affected groups.

In a concerted response to this dramatic situation, the international community, led by the International Monetary Fund (IMF) and the World Bank, urged countries to adopt stabilisation and adjustment programmes as a way out of their predicament, a position which was supported through the provision of conditionality-based loans. This advice was taken up by a large number of developing countries. The programmes which they subsequently designed, often with the assistance of the IMF and World Bank, sought to attain macroeconomic stability as indicated by a low and stable rate of inflation and sustainable balance-of-payments; restore economic growth; and initiate a process of rehabilitation and structural change - in policies, institutions and infrastructure - to maintain growth over the long-term.

Despite some successes, it became apparent in the mid- to late-1980s that stabilisation and adjustment policies were only a partial response to the crisis. There was growing evidence that the criteria of development needed to be broadened to encompass, among other things, objectives reflecting improved living standards as well as creditable macroeconomic performance; a framework for sustained and well-distributed growth; targeted programmes to assist vulnerable groups, such as children and women; and a longer time-frame for large-scale structural change. Many of these ideas were captured in proposals for "Adjustment with a Human Face" (UNICEF, 1987) and, more recently, for the pursuit of human as against exclusively economic development. The latter concept, in particular, sums up the nature of the critique. It extends well beyond economic wellbeing and conceives of development as "....a process of enlarging people's choices" (UNDP, 1990) which addresses "....the formation of human capabilities....and the use people make of their acquired capabilities - for leisure, productive purposes or being active in cultural, social and political affairs," (ibid).

Alongside this reconsideration of the adjustment experience, changes on the world stage, principally the ending of the Cold War, created conditions in the late-1980s for additional initiatives which are today beginning to influence the conceptualisation and direction of development policies. Noteworthy among these initiatives has been the United Nations Convention on the Rights of the Child which became binding on signatories in September 1990. It sets a legal and moral standard for the wellbeing of children against which to compare the conduct and accomplishments of individual nations and the international community.

The adoption of the Convention was also assisted by a unique event, the World Summit for Children, which was held at the United Nations on 29-30 September, 1990. It was attended by over 71 Heads of State/Government and, at the time, constituted the largest gathering of world leaders in history. The Summit led to the adoption of a Declaration and Plan of Action which embody a solemn commitment to achieve specific goals for the welfare of children and mothers by the year 2000. The assembled leaders also agreed to formulate national programmes of action by the end of 1991 which would define, in view of local conditions, relevant goals for the year 2000 and the feasible means of attaining them. This concrete commitment signalled growing

acceptance of a new ethic, "....an ethic which grants children a first call on our societies resources in good times and in bad; an ethic which demands that children should be the first to benefit from mankind's successes and the last to suffer from its failures," (UNICEF, 1991).

In addition to the steps taken to focus specifically on a heretofore neglected group, that is, children, there have been other developments including the World Conference on Education for All (WCEFA), the elaboration of a strategy for the Fourth United Nations Development Decade and the preparation of UNDP's ground-breaking Human Development Reports (1990, 1991, 1992). The United Nations Conference on Environment and Development/UNCED ("The Earth Summit") is also a part of this process.

II. GHANA IN THE GLOBAL CONTEXT

The evolution of events on the global stage and in sub-Saharan Africa have been reflected in Ghana. In contrast to other countries, however, Ghana's lost decade was the 1970s which led to a serious crisis by the early 1980s, compounded by natural and man-made disasters and the repatriation of about one million citizens from abroad. A few indicators reveal the depth of the crisis experienced by the country: the infant mortality rate (IMR) rose from 80 per 1000 live births in the mid-1970s to 107-120 per 1000 live births in 1983-84; between 1970 and 1982, real per capita income fell by 30 percent, national savings and investment decreased to negligible levels, net capital formation was negative, and inflation averaged 44 percent per annum (Government of Ghana/GOG, 1987).

The deepening crisis led to the launching of a comprehensive Economic Recovery Programme (ERP) in 1983. The ERP, which is still being implemented, was designed to stabilise the macroeconomic situation, restore sustained economic growth and contribute to an improvement in the living standards of Ghanaians. These objectives were meant to be attained through a multi-faceted strategy entailing the maintenance of a stable macroeconomic framework (e.g. internal and external balance, low inflation, increasing savings and investment); elimination of distortions in factor, product, and foreign exchange markets; rehabilitation and expansion of social and economic infrastructure; sectoral reforms, both social and economic, for example, in education and banking; a gradual withdrawal of the state from directly productive activities and encouragement of the private sector; and an economy well-integrated with global markets. These socio-economic strategies have been supported concurrently with an intensive programme of institutional change including a reform of the civil service and the decentralisation of major functions to regions and districts.

The GOG has also demonstrated its concern for the welfare of vulnerable groups, particularly children and women. In 1987, it launched the Programme of Actions to Mitigate the Social Costs of Adjustment (PAMSCAD) to ameliorate the negative short-term effects of the ERP as well as address some of the consequences of the preceding decade of economic decline. Ghana was also the first country to ratify the Convention on the Rights of the Child. Furthermore, it undertook an extensive programme of activities in the build-up to the World Summit. The momentum was maintained in 1991 with the signing of the Summit Declaration and Plan of Action by the Chairman of the PNDC, Flt. Lt. J. J. Rawlings, on 21 April. As a result, a Multi-Sectoral Task Force (MSTF) was established with the mandate of preparing this National Programme of Action (NPA) for presentation to the PNDC.

In a related development, Ghana has become a key participant in the UNDP/UNICEF Human Development Initiative (HDI). The groundwork for this decision was laid in 1990 and led to a joint UNDP/UNICEF Human Development Mission to Ghana in March, 1991. The main outcome of the Mission was a decision by the GOG to prepare a Human Development Strategy (HDS) Paper for presentation to the PNDC before the end of the year. It was, moreover, decided during the Mission that there would have to be close cooperation and coordination in the preparation of the HDS and NPA, in view of their common concerns. Subsequent discussions between the governmental agencies involved led to a decision to develop the Programme of Action within the broader framework of the Strategy paper, the first phase report on which was completed in December, 1991 ("Making People Matter: A Human Development Strategy for Ghana", NDPC, 1991).

III. THE PURPOSE AND STRUCTURE OF THE NPA

As will have become apparent from preceding sections, the NPA has been prepared as Ghana's response to the commitments entered into at the World Summit. It provides a situation analysis of children and women in the country, sets goals and objectives, proposes strategies, identifies resource requirements and sources of funding and, last but not least, suggests ways of monitoring progress and maintaining support at the highest level for the successful implementation of the Programme.

At this stage, it is also necessary to clarify the three main definitional and conceptual ideas underlying the NPA. Firstly, the Programme of Action uses the definition of the child provided in the Convention, that is, "....every human being below the age of eighteen years unless, under the law applicable to the child, majority is attained earlier," (Article 1). It focuses, however, on children fifteen years of age or younger who have been identified as the most vulnerable segment of the child population in Ghana. Secondly, the NPA has been formulated within the conceptual framework of human development. It is, therefore, based on the understanding that human development "...begins pre-natally...." and serves to provide a child with "....not only the basic needs of protection, food and health care, but also the basic needs for affection, interaction and stimulation, security....and learning through exploration and discovery," (UNICEF 1990). Finally, even though the emphasis is on children and, to a lesser extent, women, this should not detract from the understanding that the Programme of Action will make a major contribution to the welfare of all Ghanaians. It addresses children's concerns within the context of the needs of Ghanaian society so that a happy childhood may naturally evolve into rewarding adulthood.

CHAPTER ONE

The Evolving Situation of Children and Women in Ghana

"The Childhood Shows The Man, As Morning
Shows The Day"
- Milton's Paradise Regained

"Edwa beba a efi anopa"
(The signs of a successful market-day are seen early in the morning)
- Akan Proverb (Ghana)

"Educate a Man And You Educate An
Individual. Educate A Woman and You
Educate A Nation"
- Kwegyir Aggrey (Ghanaian Educationist)

THE EVOLVING SITUATION OF CHILDREN AND WOMEN IN GHANA

This chapter of the National Programme of Action (NPA) provides a description of the major problems afflicting children and women in the country. It is divided into three parts: the first describes the difficulties faced by children during critical phases of their life; the second illustrates the problems confronted by women in their productive and reproductive roles; and the final section discusses key issues in the household, environmental, health, education, food production and macroeconomic areas, to identify the underlying causes of the disadvantaged position of children and women. The aim is to provide a broad context for comprehending the goals and objectives as well as Sectoral Programmes of Action which are outlined in subsequent parts of the document.

It should be pointed out that the analysis presented here is, in essence, an edited and updated version of relevant parts of the Government of Ghana/UNICEF Situation Analysis of Children and Women (1990). Some limited additional information has been provided, where pertinent.

THE SITUATION OF CHILDREN

Every child which dies or survives with handicaps or whose potential is limited by shortcomings in its environment constitutes a loss and a tragedy, not only for individual families but also for the nation. Attention must be given to avoiding this loss by creating favourable conditions for the growth and development of children. As the information and analysis below clearly demonstrates, despite notable progress in recent years, Ghana still has a considerable distance to cover before it can provide its children with the standard of wellbeing and sense of security which they require to build a better future for themselves and their nation.

I. CHILD HEALTH AND NUTRITION

a. The First Twelve Months of Life

The life and health of a child can be threatened even before it is born. As a foetus, it may be adversely affected by severe chronic conditions such as maternal malnutrition, anaemia and pregnancy-related hypertension. These conditions may be complicated by severe viral infections and malaria which may all lead to foetal malformations, abortions, miscarriages, still births and low birth weight.

The most dangerous time of a child's life is, however, the neonatal period, that is, the first 28 days of life. At this stage, problems encountered in utero may come to a head, with the delivery ordeal and adaptation to a new environment. Studies (Gaisie, 1970) indicate that 45 percent of all infant deaths occur during the neonatal period after which there is a rapid decline from the fourth to the eighth month.

In contrast to the neonatal period, the second-sixth month of life may be the safest period in the life of most Ghanaian children. This is principally because the child is still closely attached to the mother through breastfeeding. This is very important for the child's protection because it provides immunity against illnesses. In fact, no serious child health problem is encountered by any breastfeeding mother who solely breastfeeds till the fourth month.

The sixth-twelveth month of life is, again, a dangerous period for the child. The pattern of ill health during this period is dominated by the cumulative burden of interaction between malnutrition and infective and parasitic diseases.

b. Infant and Child Mortality Rates (0-4 years)

In Ghana, as in many other African countries, estimates of the Infant Mortality Rate/IMR (<1 year) vary considerably because they come from different sources, creating problems for planning and programme implementation. According to the Ghana Demographic and Health Survey (GDHS, 1989), the IMR is 77 per 1000 live births (based on data covering the period 1983-1987). World Bank (1989a) estimates put the rate higher at 91 per 1000 live births. Other studies (Adjei, 1989) using community based data from 15 districts give an estimate of 96 per 1000 live births. According to Adjei's study, there was a variation from 72 per 1000

live births in urban communities (population equal to or more than 5000) to 154 per 1000 live births in rural communities (population less than 5000).

Since the GDHS is nationally-based, the figure of 77 per 1000 live births is used in this Programme of Action. The latter source also estimates the Under-Five Mortality Rate (U5MR) to be 155 per 1000 live births. This rate puts Ghana in the category of countries with very high under-five mortality (>140 per 1000 live births), the worst category in the classification developed by UNICEF for its annual report on the State of the World's Children (UNICEF, 1991).

Immediate Causes of Child Mortality

The immediate causes of infant and child mortality are shown in Tables 1.1 and 1.2 below. The data **reveal an alarming fact, that almost** 60 percent of deaths under five years of age are preventable.

Table 1.1
Major Causes of Infant Mortality

CAUSES	PERCENTAGE OF DEATHS
Low Birthweight (Prematurity)	18.8
Pneumonia	7.7
Measles	6.5
Diarrhoea	6.4
Anaemia	3.4
Malaria	3.3
Marasmus	1.3
Kwashiorkor	0.6
Tuberculosis	0.3
All Other Causes	51.7
Total Number of Deaths = 11,190	

Note: Low birthweight is a leading cause of death in those under one month; The total number of reported death certificates was 64,363 (all age groups)
Source: Ministry of Health (MOH), Death Certificates from the Centre for Health Statistics, 1979-1983

Table 1.2
Major Causes of Under-Five Mortality

DISEASE	PERCENTAGE OF DEATHS
Measles	12.6
Pneumonia	9.1
Low Birthweight (Prematurity)	8.2
Malaria	7.2
Anaemia	6.8
Diarrhoea	6.6
Kwashiorkor	3.4
Marasmus	2.7
Tuberculosis	0.6
All Other Causes	42.7
Total Number of Deaths = 25,502	

Source: As for Table 1.1

Risk Factors in Child Mortality

Risk factors in infant and child mortality include the following:

- Level of education of mother. Women with no education experience higher risk of infant and child mortality compared with those with some education. Between the ages of one and four, the probability of dying is four times greater for children of mothers with no education than for those of mothers who have more than middle school education (GDHS, 1989).

- Marital status. Unmarried mothers in Ghana tend to experience higher child loss than married mothers. Where such individuals are poor, they find it difficult to afford proper care. In addition, children also suffer from the lack of paternal care.

- The age of the mother. In general, the lowest mortality rates occur to mothers in the 20-24 and 25-29 year age groups (GDHS, 1989).

- The birth interval. The risk of dying in childhood is 1.5 times higher for children born less than two years after a preceding birth compared to those born three or more years after the preceding birth (GDHS, 1989).

- The birth order. The risk of death is usually relatively high for the first order birth. It then decreases for second and third order births but rises gradually for fourth order births and then increases sharply for fifth and higher order births (GDHS, 1989).

- The birth weight. The weight of the child at birth is a determinant factor for the child's survival. Children with low birth weights (less than 2.5 kg) generally have lower chances of survival. Causes of low birth weight include intra-uterine growth retardation which results from poor maternal nutrition, short spacing or infections during pregnancy mainly due to malaria. In Ghana, 24 percent of all supervised deliveries (in hospitals and maternity clinics) are below the international standard of 2.5 kilogrammes (MOH, MCH/FP, 1990).

- Other risk factors include low household income and inaccessibility to water, sanitation and heath facilities. These are discussed in the section dealing with underlying causes.

Regional and Rural-Urban Variations

Infant and child mortality rates show significant regional as well as rural-urban variations. According to the GDHS (1989), the infant mortality rate ranges from 58 per 1000 live births in Greater Accra Region to 138 per 1000 live births in Central Region. The infant mortality rate for Upper East, Upper West and Northern Regions combined is also high, averaging 103 per 1000 live births (Table 1.3).

In addition, urban areas have lower infant and child mortality rates than rural areas. The infant and under-five mortality rates are about 30 and 24 per cent higher, respectively, in rural compared to urban areas (Table 1.3).

Table 1.3
Infant and Child Mortality by Regional and Rural-Urban Residence
1978-87

	Infant	Childhood	Both
REGION			
Western	76.9	80.4	151.2
Central	138.3	81.9	208.8
Greater Accra	57.7	48.9	103.8
Eastern	70.1	73.2	138.1
Volta	73.5	63.8	132.7
Ashanti	69.8	80	144.2
Brong Ahafo	65	61.6	122.8
Upper West, East and Northern	103.1	132.3	221.8
RESIDENCE			
Urban	66.9	68.8	131.1
Rural	86.8	82.9	162.5

Source: GDHS 1989, p.65

Trends Over Time and Seasonality of Deaths

Table 1.4 below shows that the infant mortality rate declined from 100 per 1000 live births in 1973-77 to 77 per 1000 live births in 1983-87, a reduction of 23 percent over the space of a decade. There was, however, a break in this trend during 1983-84 which is not captured by the IMR figures in the Table. In contrast to the general trend with the IMR, the under-five mortality rate rose to 155 per 1000 live births in 1983-87 after having fallen from 187 to 152 per 1000 live births between 1973-77 and 1978-82. These developments in both the IMR and U5MR may be explained, in part, by events during 1983-84 when the impact of poor harvests, food shortages and related malnutrition was compounded by the high incidence of measles.

Table 1.4
Trends in Infant and Child Mortality

Period	Infant	Child	Both
1973-77	100	97	187
1978-82	86	72	152
1983-87	77	84	155

Source: GDHS 1989, p.64

Vital events registrations also indicate the seasonality of deaths in Ghana. Various studies (Adjei, unpublished data, 1988) have shown that periods of increased morbidity and mortality coincide with the rainy season. Unfortunately, births peak at the same period of the year, increasing the risk for both mother and new-born during the perinatal period (that is, the period starting 28 weeks after conception and ending 7 days after delivery). Deaths in children 1-4 years of age also follow the same pattern but these are heightened during epidemics as well as by malnutrition late in the lean season.

c. Child Morbidity

Age/cause specific morbidity data on children are not readily available because the routine reporting form for out-patient consultation does not register information by age group. Moreover, only a limited amount of community-based data have been collected in this area. Some information on infant and child morbidity is available from a study of out-patient attendance at Suhum District which calculated the proportional morbidity ratio (PMR), defined as the number of cases in any age group per 1000 total attendance of patients in that age group within a specified period of time (Table 1.5).

Table 1.5
Proportional Morbidity Ratio (PMR) for Selected Diseases
(Suhum Hospital)

DISEASE	AGE GROUP < 1	AGE GROUP 1 - 4
Malaria	300	450
Diarrhoeal Diseases	170	90
ARI	160	70
Measles	18	28

Source: Ashitey, unpublished data, 1986

The PMR figures confirm the fact that fever (malaria) is the most common cause of out-patient consultation (Table 1.6). This is true for both the under one and 1-4 years age groups. Diarrhoeal diseases are also common among children in Ghana, an observation confirmed by the figures in Table 1.5. Indeed, data from a survey (GDHS, 1989) show that about 34 percent of Ghanaian children have episodes of severe diarrhoea each year.

Table 1.6
Occurrence of Selected Diseases
(Number of Cases Seen, Greater Accra Region)

	YEARS				
DISEASE	1987	1988	1989	1990	1991
Malaria	183,030	209,960	283,122	261,846	268,981
URTI*	26,313	44,321	63,646	58,017	53,193
Diarrhoea	25,372	32,531	37,392	38,162	36,635
Total No. of All Disease Cases	479,136	467,309	637,853	638,320	624,301

Source: MOH (Greater Accra Region), Outpatient Statistics
*Upper Respiratory Tract Infection

Risk Factors in Child Morbidity

The morbidity risk factors in children can be categorized according to:

- The birth weight of the child. Children with low birth weight (below 2.5 kgs) are particularly vulnerable.

- The age of the child. The most dangerous period is between 6 and 12 months (as discussed in section I.a).

- The level of education of the mother. The correlation between the education of the mother and the health of the infant and child is well documented. The GDHS (1989) also reported a lower prevalence of diarrhoea among children whose mothers had higher education.

- Other risk factors contributing to morbidity in children include the lack of access to potable water, proper sanitation and health facilities as well as adequate housing, issues which are discussed in the section on underlying causes.

d. Infant and Child Nutritional Status

Malnutrition is a serious health problem among infants and children in Ghana. The National Nutrition Survey (NNS, 1986) showed, using the U.S.-NCHS standard, that protein energy malnutrition (PEM) was high among children 0-60 months of age. It found that:

- 58.5 percent of the age group were underweight (below 80 percent of the weight-for-age standard), twice the level reported in the first National Nutrition Survey in 1961-62;
- 51.5 percent were stunted (height-for-age below 90 percent of the standard);
- 40.3 percent were wasted (weight-for-height below 80 percent of the standard); and
- 8 percent were clinically classifiable as suffering from marasmus and kwashiorkor (that is, were severely malnourished).

More recent surveys suggest a notable improvement in nutritional status. An analysis by Alderman (1991), based on data from the GLSS (1989) and using the same standards as the NNS, found that, among children under five years of age:

- 31.4 percent were underweight;
- 19.6 percent were stunted; and
- 5.1 percent were wasted.

Using an alternative measure of nutritional status based on the same data but using a cut-off of two standard deviations below the U.S.-NCHS reference median, Alderman (ibid) found that among the same age group:

- 20.3 percent were underweight (below the reference median for weight-for-age);
- 31 percent were stunted (below the reference median for height-for-age); and
- 7.9 percent were wasted (below the reference median for weight-for-height).

In addition, the GDHS (1989) estimated that 31 percent of children aged 3-36 months were two or more standard deviations below the reference median for weight-for-age.

Other nutritional deficiencies in infants and children include nutritional anaemia which is aggravated by malaria, other infections and intestinal worm infestations. Vitamin A deficiency/xerophthalmia is also prevalent in the northern part of the country. On the basis of baseline studies in the Northern Region, however, Rosster (1977) concluded that vitamin A deficiency was not a problem in the area. In contrast, the regional health authorities considered it to be the third most serious health problem after PEM and anaemia (ibid). A more recent study, the Ghana Vitamin A Supplementation Trials/VAST (1990), found the prevalence rate for

xerophthalmia to be approximately 1.6 percent in the Kassena-Nankana district of the Upper East Region. The study also reported that children suffer from severe deficits in the intake of vitamin A, riboflavine and vitamin C during both the pre- and post-harvest periods. Thus, only about 13 percent and 8 percent of vitamin A and vitamin C requirements were being met, on average, during the pre-harvest period. On the other hand, thiamine and niacin intakes were found to be more than adequate during both the pre- and post-harvest periods.

With regard to other micronutrient deficiencies, the NNS (1986) found 10.7 percent of the population surveyed in the Upper Regions to be suffering from goitre, which is a manifestation of iodine deficiency disorder (IDD). Estimates reported by the World Bank (1989a) suggest that goitre may affect almost one-third of the population in parts of the Northern and Ashanti Regions.

Nutritional Risk Factors

Nutritional risk factors in Ghana include food availability, types of foodstuffs consumed and their nutritional value and food distribution within the family, with particular emphasis on inequalities by gender. With infants and young children, breastfeeding, supplementation and weaning are also important factors. In this regard, the age of the child at supplementation or weaning is of critical significance.

To elaborate on some of the risk factors, it is evident from survey data (NNS, GDHS) that breastfeeding is almost universal in Ghana. It is concentrated between 6 to 18 months and, in some cases, lasts for more than 18 months. Despite this relatively impressive habit of breastfeeding, there are specific related habits which tend to deprive infants of vital nourishment. In some areas, for example, infants do not receive their first breastfeeding until the second, third or even fourth day after birth because of a belief that the colostrum is harmful for the infant.

With regard to weaning, there does not appear to be a definite weaning period in Ghana. While weaning periods ranging from 6 months to three years are not uncommon, children are introduced to food other than breastmilk too early (District Profile Survey/DPS, 1985). The reasons for early weaning are varied. In some cases, children may be weaned suddenly when the mother becomes pregnant again. In other instances, mothers wean their children when they believe their breastmilk to be inadequate or because they want to return to work as early as possible.

II. CHILDREN'S EDUCATION

Since the 1950s, successive governments in Ghana, realizing the importance of education for social and economic development, have formulated and implemented policies with the principal goal of improving and extending access to education. Thus, the Education Act of 1961 had the objective of attaining universal primary enrolment. In fact, since independence (1957), both the absolute numbers and percentages of children in school have risen. Inspite of these achievements, however, factors such as a rapidly growing school-age population, low enrolment and high drop-out rates drew attention to the need for continued educational improvement and expansion. As a result, during the early part of the 1970s, attention was focused on issues of equity, quality, access and relevance of education. In response, the government embarked on an educational reform programme in 1974 which failed to make progress due to lack of political will and inadequate funding, the latter resulting from the protracted period of economic decline which began in the 1970s. Educational performance and achievement at the basic education level deteriorated markedly in subsequent years.

Since 1987, however, the government has embarked on an Education Reform Programme aimed at improving access, quality, efficiency and equity in the sector. Among the achievements of this programme have been the reduction of pre-university education from 17 to 12 years, growing enrolments in basic education, improved relevance of the curricula for basic and secondary education, expanded and strengthened teacher training and a greater emphasis on sustainable financing through cost reduction and cost sharing. In parallel with the programme, a large-scale effort is underway to eradicate adult illiteracy by the year 2000, using non-formal educational methods.

A major drawback of the reforms, however, is their neglect of pre-school education. Furthermore, there continue to be substantial disparities among the regions and rural-urban areas of the country in terms of access to and quality of education. In addition, girls' education continues to lag behind that of boys (see section b. below). Hence, despite impressive changes in recent years, education policymakers, planners and administrators still face serious obstacles to the attainment of their objectives.

a. Pre-School Education

Relatively few children in Ghana have access to pre-school education. Nationally, less than 10 percent of the eligible age group (under 6) are enroled in pre-schools (communication from the MOE, 1992). Table 1.7 below also shows significant regional variations in the availability of, and enrolments in, pre-schools. The worst-off regions are Northern, Upper East, Upper West and Central.

Table 1.7
Number of Pre-Schools and Enrolment by Region and Sex, 1987/88
(Public and Private Pre-Schools Registered with the GES)

	No. of Schools	Enrolment		
Region		Girls	Boys	Total
Gt. Accra	450	15,804	16,234	32,038
Eastern	429	16,415	13,986	30,401
Central	205	5,477	5,079	10,556
Western	555	22,610	23,812	46,422
Volta	452	13,049	13,280	26,329
Ashanti	662	23,531	23,527	47,058
B. Ahafo	498	15,820	13,712	29,532
Northern	91	3,748	2,753	6,501
U. West	18	782	601	1,383
U. East	14	722	635	1,357
All Regions	3,374	117,958	113,619	231,577

Source: Communication from the Ministry of Eduation (MOE), 1990

A survey on pre-school services in Ghana (Ghana National Commission on Children/GNCC, 1984), found that about 90 percent of the staff in pre-school units did not have proper academic qualifications. The survey also noted problems of overcrowding, especially in rural areas. Moreover, about 70 percent of the pre-school units surveyed lacked proper health care surveillance, with the situation being worst, once again, in rural areas. Lack of play facilities was also found to be a general problem. Approximately half of the units in the survey had no playthings at all.

The deplorable state of pre-schools in Ghana is a consequence, in part, of the absence of an updated and comprehensive policy framework which sets out the objectives, organisation and content of education for the 0-6 age group. Currently, the MOE (through the Ghana Education Service/GES) and the Department of Social Welfare (DSW) are the main sources of staff for pre-school centres under their supervision. District Assemblies also play an important role in recruiting staff for pre-school units under their control, upon recommendation by the DSW. Since 1985, the 31st December Women's Movement has been providing day-care facilities and playthings.

b. Primary Education

According to the Ministry of Education (MOE, 1992), the gross enrolment ratio in primary schools was an impressive 82.5 percent in 1990 compared to 80.5 percent in 1988. Earlier data from the Ghana Living Standards Survey (GLSS, 1989), however, show that the net enrolment rate was about 67 percent in 1988-89 (that is, enrolment among the relevant age group, 6-11 years).

It is evident, therefore, that while the situation is improving, almost a third of Ghanaian children in the appropriate age group are still not enroled in primary schools. The state of primary education looks even worse when the drop-out rate is taken into account. The magnitude of the latter phenomenon is evident from Table 1.8 below. Among the cohort entering primary school in 1978/79, the rate of "wastage", defined as the proportion of first year enrolment which had dropped out by the final year, was 27 percent and 36 percent for boys and girls, respectively. More recent data from the MOE (PBME Division, 1988/89) are even more alarming because they suggest an increase in the rate of "wastage". They show that grade six enrolment as a percentage of grade one enrolment was 64 percent and 54 percent for boys and girls, respectively. This means that 36 percent of boys and 46 percent of girls had dropped out over the six years of primary school, yielding a school completion rate of only 60 percent, which is unacceptably low.

Table 1.8
Dropouts: Primary/Junior Secondary School Cohorts by Sex
1978/79 - 1987/88

		Boys			Girls		
Year	Class	Enrolment	Retention Cohort	Dropouts %	Enrolment	Retention Cohort	Dropouts %
1978/79	P1	155,847	1,000	-	130,303	1,000	-
1979/80	P2	134,269	862	13.8	111,104	853	14.7
1980/81	P3	128,571	825	3.7	102,780	789	6.4
1981/82	P4	126,056	809	1.6	90,225	754	3.5
1982/83	P5	122,828	788	2.1	93,413	717	3.7
1983/84	P6	113,652	729	5.9	83,319	639	7.8
1984/85	M1	83,922	538	19.1	59,660	458	18.1
1985/86	M2	82,460	529	0.9	56,800	436	2.2
1986/87	M3	76,563	491	3.8	50,410	387	4.9
1987/88	M4	66,930	492	6.2	42,040	323	6.4

Source: Pandit H.N., et.al, 1989

There are also disturbing gender and spatial disparities in access to education. While girls account for almost half of total enrolment in primary schools located in Greater Accra Region, the figure is only 33 percent in the Northern Region. Low enrolment among girls is compounded in the northern zone of Ghana by very high drop-out rates. Thus, the annual average drop-out rate for girls in the Northern and Upper Regions is about 20 percent and 18 percent, respectively, a situation which does not bode well for the current and future status of girls and women in these areas. Finally, with regard to the distribution of resources in education, 91 percent of teachers in the Greater Accra Region are trained compared to just 45 percent in the Northern Region. These characteristics hold true for junior secondary schools as well.

III. THE CHILD IN THE FAMILY AND IN SOCIETY

a. The Child in the Family

The child requires a defined social and cultural milieu and specific social structures, such as a family, to aid his/her successful integration into society. Rapid socio-economic changes notwithstanding, the Ghanaian family remains primarily of the extended type, within both urban and rural communities. Even where there is physical isolation of the nuclear family, as is the case with the urban middle and upper classes, the long arm of the extended family manages to reach the small family unit in one way or another. This means that a wide range of relations - grandparents, aunts and cousins - have some role to play in the upbringing of the young child, although the mother remains the child's first and most important social contact. Grandmothers, in particular, have been found to have a strong influence on the upbringing of children. The degree of influence exerted by the various members of the extended family depends, however, on whether the family is matrilineal or patrilineal and whether the child is from a monogamous or polygamous setting.

Another important influence on the growth of Ghanaian children in urban areas are the maidservants or househelp who are employed by working mothers to look after their children during working hours. These maids spend a lot of time with the children and exert significant influence on them.

b. The Child in Society

Certain cultural and social ceremonies and rites are an important part of a child's upbringing in Ghana. There is, for instance, the ceremony of outdooring at which a week-old child is publicly and ritually introduced into the family unit as well as society. The child is subsequently given a name.

Puberty rites are also common among some ethnic groups but they are mostly practised in rural areas. These rites are designed to usher young girls into adolescence. During the ceremony, the girl is instructed on her role as a person who has been socially approved to be mature for marriage. She is taught the nuances of marital life and the art of home-making such as cooking and the care of children, husband and in-laws. Various ethnic groups also have transitional provisions and rites for boys which mark their passage from boyhood, and a status of dependency, to a potentially independent status. The rites signal that the boy can earn a living through fishing or farming and take a wife if he so desires.

Traditionally, social upbringing proceeds along gender lines which clearly demarcate the respective responsibilities of males and females. Thus, girls are invariably prepared for their future roles as mothers, housewives and income earners. Some may even be given out in marriage and begin to bear children before they are 15 years old. With regard to boys, from the age of six years onwards, they follow their fathers on various activities - fishing, farming and hunting - and become acquainted with the labour and commercial markets.

IV. CHILDREN IN ESPECIALLY DIFFICULT SITUATIONS

a. Orphaned and Abandoned Children

Ghanaian social systems have in-built structures through which members of the extended family are cared for, especially in times of need. In the traditional system, crisis in the nuclear family may lead to kin and occasionally non-kin child fostering, as a type of welfare system within the family structure. As a result of socio-economic changes such as increased urbanisation, however, many families are being forced to move away from the old securities of the extended family system. In urban areas, in particular, alternatives to traditional fostering have had to be established. Institutional care for certain portions of the child population has, consequently, become important in Ghana.

The concept of institutional care for urban children, believed to be lacking in parental or foster parental care and protection, dates back to the 1940s when the Ghana Hostels Association was formed with the objective of finding foster parents for such children. In 1962, the National Trust Fund helped to build the first Home, the Osu Children's Home, to provide permanent accommodation for such children. The Government of Ghana,

through the DSW, assumed full responsibility for the maintenance and running of the various Homes. This responsibility was given legal sanction by an Act of Parliament (the Criminal Procedure Code/Act 30 of 1960 amended by Act 177/Section 30).

The objective of the Homes, whether supported by the state or voluntary organizations and church bodies, is the same - to provide near-equivalent natural homes for children whose parents are, for some reason, unable to or incapable of fulfilling their responsibilities or are deceased. It should be emphasized that the state only assumes care-taking responsibilities when all investigations affirm that there are no identifiable kinsmen who are willing and able to accept such a responsibility. To the extent possible, a child's stay at a Home is designed to be a temporary one, with efforts made to find a natural home, if necessary through the process of adoption.

b. Disabled Children

This phenomenon has not been defined precisely in Ghana nor is it well understood, given the paucity of valid and recent data, particularly with regard to mental disabilities. This is partly due to some cultural factors which discourage parents from registering their disabled children; according to the DSW, only 100 disabled persons are currently registered per million population.

To elaborate on some of the cultural factors militating against registration, it is considered taboo in most traditional societies in the country to have a disabled person within the family. Disability is seen as a curse from the gods or punishment to the family for past misdeeds. Some people even consider it to be hereditary. Not surprisingly, few people want to marry into a family with disability.

In the early sixties, it was estimated that the prevalence of permanent disablement in Ghana was about 11.6 per thousand population or about 100,000 persons (John Wilson Report, 1960). Ofosu-Amaah et. al. (1977), using the results of a national survey, estimated the prevalence of lameness to be 5.8 per thousand children below the age of five. On the basis of this finding, they also estimated that the annual incidence of paralytic poliomyelitis could be about 23 per 100,000 population annually. More recent estimates from the DSW suggest that the incidence of physical disability was 10 per 100,000 population in 1991 (communication from the DSW, 1992).

In 1986, about 44,000 disabled persons were registered with the DSW (Table 1.9).

Table 1.9
Registered Disabled Persons in Ghana By Disability and Gender, 1986

Disability	Male	%	Female	%	Total	%
Blind	9,152	64.9	4,959	35.1	14,111	100.00
Deaf	4,379	65.3	2,326	34.7	6,705	100.00
Cripple	15,585	69.5	7,223	30.5	22,808	100.00
All types	29,116	66.7	14,508	33.3	43,624	100.00

Source: Register of Disabled Persons, DWS, 1986

Table 1.10 below provides a disaggregation of earlier data on disability by age and gender for those aged 0-15 years . It shows that boys are apparently worse affected by disability. This inference should be treated with caution since the sample is not representative of the general population.

Table 1.10
Disabled Children by Age and Sex (Absolute Figures), 1980

Type of Disability	0-5 Years		6-15 Years		Total
	Male	Female	Male	Female	
Blind	29	26	679	497	1231
Deaf	137	88	1636	1064	2925
Cripple	566	325	3778	2410	7079
All types	732	439	6093	3971	11235

Source: DSW quoted from UNICEF 1984

There is a pressing need to change attitudes towards the disabled held by society and the disabled themselves. To a large extent, society encourages idleness among the disabled, based on the false premise that they are incapable of earning a livelihood, making them the objects of pity and sympathy. As a direct result, the disabled child comes to accept this perspective and attributes its disability to supernatural punishment or witchcraft, thus, fostering a dependency syndrome of self-pity and helplessness.

Limited assistance is provided to the disabled by several voluntary organisations as well as the DSW. Nevertheless, a lack of resources and facilities, reflecting the low priority assigned to this issue by society, has seriously detracted from the scale and quality of efforts, especially in the case of assistance to the mentally disabled. The tragedy is that the physical disabilities identified can be largely prevented through cost-effective interventions centred on improving the quality and availability of perinatal care, expanding the coverage of immunisation services and developing balanced diets for better nutrition.

c. Teenage Pregnancy

Teenage pregnancies are a serious problem in the country. Although reliable survey data are unavailable, anecdotal evidence seems to support the view that a significant number of young girls (including those under the age of 15) are becoming mothers. Table 1.11 below provides data on the percentage of teenagers among those attending antenatal clinics during 1987-90.

Table 1.11
Proportion of Teenagers Among Those Attending Antenatal Clinics, 1987-90

YEAR	% TEENAGE
1987	21
1988	30
1989	27
1990	22

Source: MOH, MCH/FP Annual Reports, 1987-90

A major area of concern with teenage pregnancy are the large numbers of unwanted pregnancies and related recourse to induced abortions. Although adequate data on the magnitude of induced abortions among Ghanaian adolescents is limited, the figures are believed to be high (Sai, 1984; Gyepi-Gabrah, 1985). From his research among the Kwabu in 1976, Bleek (1990) was led to make the alarming suggestion that among the generation of young women (up to 25 years of age), nearly 100 percent had attempted an abortion during a first pregnancy. Adjei in his case control study (1986) indicated that 60.3 percent of pregnancies among girls under 20 years of age were unwanted and that the rate of abortion was 22.1 percent of these cases. These figures clearly suggest that the phenomenon of teenage pregnancy is a serious threat to the mental and physical health of teenage girls.

Teenage pregnancy may also lead to a number of family and social difficulties, especially when the girl comes from a lower income household, as is often the case. These include high-risk pregnancies for both mother and child, disruption of schooling and the imposition of additional burdens on poor households in cases where the male partner refuses to take financial responsibility for the child.

d. Female Circumcision

Studies conducted by Kadri (unpublished, 1986) and Twumasi (1988) reported the practice of female circumcision in the Northern and Upper Regions and also in Northern migrant settlement areas in Accra. Some of the reasons given for this practice include pre-condition for marriage, test of virginity and religious imperatives. Medical evidence shows that female circumcision complicates child birth and increases the risk of maternal death.

The Ghanaian Association for Women's Welfare, in collaboration with the 31st December Women's Movement, has attempted to address this problem through educational campaigns targeted at those tribes and communities still engaged in the practice. Traditional authorities are being urged to initiate reform within their areas of jurisdiction.

e. Child Labour

In Ghana, the term "child labour" applies by law to children under 16 years of age. Specifically, paragraph 31 of the Labour Decree states that "No person who in the opinion of the Chief Labour Officer or a Labour Officer is under the age of sixteen shall be capable of entering into a contract for employment as a worker."

Within the Ghanaian context, a person is deemed to be contracting child labour under the following conditions: if the work is preventing the child from attending school and acquiring relevant skills for adult roles and responsibilities; if the child is exposed to danger, both physical and mental; if the work is so excessive and strenuous as to cause harm to the child in whatever form; and if there is wilful and deliberate exploitation of the child for solely profit motives, taking undue advantage of his/her naivete, innocence and immaturity.

It should be apparent from the above that the performance of work by a child may not automatically connote child labour. Indeed, in a poor developing society like Ghana there is a certain ambiguity in the comprehension and application of the term "child labour". In such socio-economic circumstances, children are often regarded as an economic asset and as security for old age. Certain types of activities are, therefore, reserved for children, tasks such as fetching wood and carrying water. The assumption is that children will learn through their active participation in work within and outside their home. They are, thus, "apprenticed" to their parents at an early age. This enables them to acquire a vocation and, concurrently, become socialised to their specific milieu. The pressure to use children in this manner increases during periods of economic crisis, as experienced by Ghana in the early 1980s. While the crisis has receded, there is still considerable economic pressure on households in both rural and urban areas.

To a significant extent, therefore, "child labour" cannot be eliminated. In fact, it also serves a useful purpose to the extent that it is a non-coercive and non-exploitative form of socialisation. Nevertheless, socialisation may camouflage or degenerate into exploitation. This is particularly applicable in cases where children are engaged as maid servants, hawkers, cart-pushers and carriers at construction sites.

The challenge facing government and society is to deal firmly with cases of exploitation while, at the same time, acknowledging children's roles as productive members of their family. Acknowledgement should not, however, imply passivity, for it is possible to lessen the negative impact of work on children by designing basic services around local practices, for example, by using non-formal education, by integrating apprenticeship and literacy programmes and by scheduling immunisation sessions during non-productive hours. Care should also be taken to avoid losing sight of the final objective, that is, to ensure that children are only engaged in those activities from which they derive an unambiguous benefit.

f. Child Migration

There is a general lack of reliable information on the extent of this problem since what exists in terms of data relates to migration by adults/parents. The situation of migrant children must, as a result, be gleaned through inferences from data on the adult population. A study currently underway should shed more light on this phenomenon.

The problem is built into the social and economic norms of the country. It is not considered wrong, for instance, that a 12 or 14 year old boy should leave the village for the city to look for work. Many migrant children arrive at their destinations with serious handicaps - lack of adequate education or training for urban jobs, emotional immaturity and inadequate information about town/city life. The children find themselves on the fringes of towns and cities, mainly in slum areas or "zongos" (areas where newcomers normally reside). At best, they may get a poor education and at worst they may not go to school at all. The majority simply end up in the already crowded market for child labour. Migrant children may also become juvenile delinquents.

g. Drug Abuse

Drug abuse has the potential for becoming a very serious social problem, especially among the under 18 year olds. The most common phenomenon is addiction to tobacco, marijuana, cocaine and heroin. There is also abuse of common drugs such as pain-killers, antibiotics, laxatives and others in the treatment of child illnesses (communication from the Psychiatric Hospital/Accra, 1992). The latter category does not pose as serious a threat as the former.

Information from the Ghana Police Service indicates that teenagers are being used as transporters of drugs. Table 1.12 below shows the proportion of teenagers involved in drug seizures during 1987-1989.

Table 1.12
Drug Seizure Returns

Year	Type of Drug	Gen.	Teen	% Teen	Total Wt(Gm)
1987	Marijuana	598	105	17.5	4,086,502.90
	Cocaine	11	-	-	91.65
	Heroin	18	6	33.3	1,380.14
1988	Marijuana	838	200	24.0	6,719,926.20
	Cocaine	3	-	-	25,008.00
	Heroin	23	10	43.5	1,200.63
1989	Marijuana	1,145	269	24.5	9,858,225.40
	Cocaine	4	-	-	355.70
	Heroin	45	13	29.0	1,696.31

Source:Ghana Police Service Hq., Accra, Oct. 1991

h. Child Delinquency

Although studies on this phenomenon have not been made, observations suggest that the most affected groups include school drop-outs, those from broken homes and orphans. Delinquency itself may take various forms such as petty theft, violent behaviour towards elders, assault and general misdemeanour. Recently, however, there have been cases of drug trafficking, as indicated in Table 1.12 above, and armed robbery. The likely causes of delinquency may be surmised as peer group pressure, drug addiction, desire for money and a general frustration with family life. When offenders are apprehended, the cases are usually settled in Juvenile Courts with those convicted being put in Remand and Probation Homes as well as industrial/vocational training schools (depending on the duration of conviction).

There may also be a relationship between the incidence of delinquent behaviour and the presence of increasing numbers of children of school-going age on the street and in market places, lorry parks, beaches, video centres and recreational grounds during school hours. The phenomenon has become sufficiently noticeable to cause concern on the part of the Government and those concerned with child welfare. The children most at risk are orphans, those from broken homes and migrant children.

V. THE LEGAL STATUS OF CHILDREN

Ghana has a number of laws which affect the welfare of children by protecting them from economic exploitation and promoting their development. Nevertheless, while these legal provisions contain elements which are convergent with the United Nations Convention on the Rights of the Child, there is still considerable scope for improvement.

Some of the laws and their strengths and weaknesses are as follows:

(i) Unlike the Convention (Article 1) which provides a single definition for a child as someone at most eighteen years of age or younger (if prescribed by national law), Ghanaian laws attach different meanings to the term "child" depending on the context in which it is applied. Hence, varying upper limits on age are contained in the Labour Decree, Criminal Procedure Code and the Cinematograph Act.

(ii) The Directive Principles of State Policy embodied in the 1979 Constitution as well as the PNDC Establishment Proclamation Law protect children from all forms of discrimination. Yet, certain customs in Ghanaian society still work to the disadvantage of particular groups, for example, female children and the handicapped. These customs are only partially addressed in legislation.

(iii) In accordance with Article 15 of the Convention, the Education Act of 1961 provides for compulsory education for all children though it does not specify the minimum number of years of schooling. Unfortunately, it has not been possible to enforce this law.

(iv) As regards child stealing, the law only relates to crimes committed against those under the age of twelve, a feature that requires amendment.

(v) As has already been pointed out, the rights of disabled children necessitate further attention, not least in terms of the facilities available for their education which are currently very few in number.

It is noteworthy that Ghana was the first country to ratify the Convention on the Rights of the Child. This may be taken as a sign that the country is moving towards creating a framework more conducive to the rights of children including building mechanisms for enforcement of those rights.

THE SITUATION OF WOMEN

There exist close causal links between the low socio-economic status of women and high rates of infant and child mortality and morbidity and poor nutritional status. This is because women are almost universally responsible for the care of children, the sick and the disabled. Furthermore, women's reproductive functions often result in their shouldering a disproportionately large share of responsibility for childrearing, nurturance and the provisioning of basic needs. While the condition of women cannot be divorced from that of the economy and society in which they live, it is also generally accepted that a correlation exists between women's position in the family, their educational levels and employment status and their ability to exercise control and choice over crucial aspects of their lives. This, in turn, has a large impact on the health and welfare of children.

I. MATERNAL HEALTH AND NUTRITION

a. Maternal Mortality

The Maternal Mortality Rate (MMR) was estimated to be 5-10 per 1000 live births in the mid-1970s. Since then, no validated community-based data has been collected to provide an up-to-date figure for the MMR. In the absence of better information, use has been made of hospital-based statistics which only record the maternal death ratio but not the rate. However, trends can be compared using these ratios, based on data from any given institution. Thus, for the period 1963-67, Ampofo (1969) found a maternal death ratio of 10.8 per 1000 live births in the Korle-Bu Teaching Hospital. Twenty years later, Antwi et. al. (unpublished, 1989) found a death ratio of 7.9 per 1000 live births for the period 1986-88, an improvement of only 21 percent since 1963-67.

Immediate Causes of Maternal Mortality

The immediate causes of maternal death can be divided into two categories, direct and indirect. A study by Antwi et. al. (unpublished, 1989) using hospital-based data found that the leading direct cause of death was haemorrhage, of which post-partum haemorrhage was the main contributing factor. This was followed by septicemia and pregnancy-related hypertensive diseases, among which eclampsia was the most significant. It is noteworthy that all these three direct causes, which account for 42 percent of maternal deaths, are preventable to a significant extent. Indirect causes, which account for 32 percent of all maternal deaths, are incidental to the mother. Sickle cell disease was found to be the main factor, followed by anaemia and other respiratory and cardio-vascular diseases. It should be noted that hospital-based data may not be representative of the actual situation. Nevertheless, in the absence of other recent information on the causes of maternal mortality, the analysis by Antwi et. al. provides some indication of prevailing conditions.

Risk Factors in Maternal Mortality

Risk factors affecting maternal mortality include the age of the mother, the parity of the mother, haemoglobin levels and stunting. High-risk pregnancies, therefore, include those before age 18, after age 35, after four births and less than two years apart. Higher-risk pregnancies are more likely to develop haemorrhage or pregnancy-related hypertension. If pregnancies are closely spaced, they may undermine the mother's health and nutrition, a hazard that can be avoided through family planning.

b. Morbidity Among Women

The causes of maternal morbidity may be conveniently grouped under pregnancy-related complications and water-related/poor environmental sanitation diseases which affect the population generally. To these can be added malnutrition resulting in anaemia and sexually transmitted diseases such as gonorrhoea, syphilis, HIV seropositivity and AIDS (World Bank, 1989a).

c. Malnutrition Among Women

Malnutrition among women is a major health problem, especially during pregnancy. A survey (Orraca-Tetteh, et. al., 1976) in Baafi, located in the Eastern Region, showed that pregnant women were meeting only 75 percent and 60 percent of their recommended caloric and protein intake, respectively. Micro-nutrient deficiencies are also common among women in Ghana. The most prevalent is iron-deficiency anaemia although vitamin A deficiency is also severe (but more concentrated in the three northern regions). As mentioned earlier, goitre, caused by iodine deficiency (IDD), is estimated to affect up to a third of the population in parts of the Northern and Ashanti Regions (World Bank, 1989a). It is also believed to be prevalent in other areas of the country, for example, the Upper Regions (NNS, 1986).

In keeping with the patterns for other socio-economic indicators and consistent with harsher ecological, climatic and living conditions, the northern regions of Ghana have a greater prevalence of malnutrition compared to the rest of the country. In 1986, 65 percent of pregnant women and 45 percent of non-pregnant women examined in northern Ghana showed symptoms of protein-energy malnutrition (ibid). In contrast, 43 percent of pregnant women and 30 percent of non-pregnant women suffered from protein-energy malnutrition in the south.

According to available data (ibid), the prevalence of all the indices of maternal malnutrition is higher in rural vis-a-vis urban areas. The prevalence of low fatfold was particularly severe in rural areas where women tend to use up more energy and caloric reserves working on the farm.

In addition to the above, certain cultural practices combine with harsh living conditions to increase the incidence of malnutrition among women. To take a case in point, adult males are usually served the best portions of meals with the remains going to women and children. In some Ghanaian societies, it is taboo for pregnant women to eat certain food items like eggs and meat even though these are highly nutritious and essential during pregnancy.

II. WOMEN'S EDUCATION

In 1984, the proportion of the total population aged six years and above who had been to school was 56.5 percent compared to 43.2 percent in 1970. The proportions for males and females were 52.7 percent and 33.8 percent, respectively, in 1970 and 67.7 percent and 48.2 percent, respectively, in 1984. By age, the proportions of the population who had been to school were higher in the 6-14 years and 15-24 years cohorts. However, in all age-groups, the proportion of males was higher than females.

The literacy rate of the population 9 years and over is currently estimated at 32.5 percent; whereas the rate for males is 42 percent, that for females is only 23 percent (GLSS, 1989). Literacy rates are generally high for both sexes between ages 15-34 years but fall rapidly for women in succeeding age groups. Rural-urban differences exist for all age groups (Table 1.13).

Table 1.13
Literacy and Numeracy Rates by Locality (Present)

	Accra			Other Urban			Rural			Country		
	Male	Fem.	Tot.	Male	Fem.	Tot.	Male	Fem.	Tot.	Male	Fem.	Tot.
Read	78.5	61.8	70.1	52.4	31.4	41.3	37.7	18.3	27.7	45.5	25.9	35.4
Write	71.1	54.9	63.3	49.0	28.3	38.3	35.0	16.6	25.5	42.2	23.4	32.5
Do Arith-metic	85.3	71.0	78.1	66.8	44.7	55.2	52.4	29.8	40.8	59.4	37.7	48.1

Source: GLSS 1989, p.57

III. WOMEN IN THE FAMILY AND IN SOCIETY

a. Women in the Family

The family is recognised as the basic social unit in all Ghanaian societies. For some time now, however, it has come under considerable strain. The incidence of broken homes, child delinquency and the increasing numbers of children roaming the streets pose problems which society cannot afford to ignore.

The position of a woman in the family is often dependent on whether she is married, single or widowed and young or old. She is valued because of her reproductive abilities (as the guarantor of the family line) and her role in providing food, cooking, fetching water and fuelwood, washing, taking care of children, the sick and the aged, and promoting the health and wellbeing of other family members. In spite of these, there exists a situation of gender inequality as has been noted already and men enjoy a dominant position within the family or household compared to women. This is reinforced by social, cultural and religious beliefs and practices which demand, for example, that men be served the best food and be freed from certain tasks.

Even where women are heads of household, they do not always enjoy the same authority as men and may have to refer issues relating to children to male kin. The GLSS (1989) has shown that 29 percent of households in Ghana are headed by females compared to 28.8 percent recorded in the 1984 Census. The proportion of female-headed households is highest in urban areas excluding Accra (32.9 percent) but in both rural and urban societies, the phenomenon may be on the increase.

Marital Status

A majority of Ghanaian women have either been married at one time or another or live in consensual unions (GDHS, 1989). At 15-19 years of age, 17 percent of the women are already married and a further 3.5 percent live in consensual unions. Marital rates increase rapidly in successive cohorts and by 25 years of age, less than 5 percent of women have never been married.

Fertility

The average Ghanaian woman can expect to bear 6.4 children during her reproductive years (GDHS, 1989), a slight decrease from the 6.71 children recorded by the Ghana Fertility Survey (GFS, 1979). In the decade since the GFS, total fertility rates have remained the same for women with no education (GDHS, 1989). Neither have there been significant changes in the fertility behaviour of primary and middle school educated women. As in 1979, it is after higher education that significant differentials emerge in fertility.

In the area of family planning, the GDHS (1989) reveals that even though knowledge of contraceptive methods is fairly high, knowledge of sources and use have not kept pace. Thus, 69.8 percent of all women know the source for any method of contraception compared to 76.2 percent who know of methods. Furthermore, while the percentage of currently married women currently using contraception was found to have risen, from 9.5 percent in 1978/79 to 12.5 percent in 1988, it was still at a very low level. Use of modern methods was more limited at about 5 percent in 1988.

b. The Economic Role of Women

Farming is the single most important occupation for rural women who constitute 50 percent of all workers in agriculture and animal husbandry. A smaller proportion of women are classified as farmers and farm managers, representing only 25 percent of that category (Population Census, 1984). Women are also actively involved in agro-based industries such as gari-processing, palm oil and sheanut extraction and fish smoking. Other small-scale industries include pottery-making and handicrafts production. A small proportion of rural women also engage in trading, in addition to their normal undertakings, and retail imported and domestic manufactured items in local markets and on an itinerant basis.

In the urban areas of Ghana, women have to deal with the numerous socio-economic constraints and difficulties of urban life in addition to problems arising from their gender. For most women in urban areas, access to the formal job market is quite restricted as they do not possess the requirements for entry such as good educational qualifications and skills. Early marriages and teenage pregnancies also deprive young women of opportunities to enter and survive in the labour market.

The informal sector constitutes the most important source of employment for the majority of working urban women, in areas like trading, small-scale and cottage industries. Most informal sector workers are self-employed and depend on their own resources for survival. The majority have no formal education, are middle-aged and cater for many children and dependents. Like rural women, urban women are also wholly responsible for domestic work although they are able to rely, to a greater extent, on paid assistants or unpaid family helpers. Removed from the support of immediate kin, urban women are, however, experiencing increased conflicts between their domestic chores, employment and other responsibilities.

UNDERLYING CAUSES

I. CHANGES IN INCOMES

Although real GDP per capita increased by more than 15 percent between 1984-90 (Alderman, 1991), there are still questions about the extent of success in translating this gain into substantial growth in household real incomes to satisfy basic needs. For example, given the high rate of inflation as well as the slow pace of increase in income and questions about its distribution (see below), it is possible to argue that a significant proportion of the population may have experienced declining purchasing power over this period. An indicator of this situation is the index of real minimum wages (1970=100) which increased steadily from the trough in 1983 till 1985 but then declined consistently till 1988 (though still at a higher level than in 1983). Indeed, the real minimum wage in 1988 retained only about 30 percent of its value in 1970. It should be noted, however, that the minimum wage acts as a floor only in the urban formal sector whereas most of the population is either employed in farming or the informal sector where wage levels reflect underemployment and low productivity.

Data from the GLSS (1989) show that there are not wide disparities in income between the poorest and richest quintiles of the Ghanaian population. The survey, nevertheless, reveals marked inequalities by type of productive activity, rural or urban residence and regional location (World Bank, 1989c). Thus, farmers are the worst-off group, with cocoa farmers doing somewhat better than food producers; nearly two-thirds of the poorest 10 percent and 30 percent of the population are found in rural communities with less than 1,500 inhabitants; and about 60 percent of the poorest tenth of the population are located in Northern Ghana with the other 40 percent split evenly between the Coastal and Forest Zones.

There is also some evidence indicating that there may have been an increase in both the absolute numbers and proportion of the poor in the total population up to the mid-1980s. A study undertaken by the International Fund for Agricultural Development (IFAD, 1988), which determined a poverty line for the country, revealed that the number of smallholders below the benchmark had almost doubled from 1.95 million in 1970 to 3.8 million in 1986, representing 23 percent and 29 percent, respectively, of Ghana's population. Consistent with later evidence from the GLSS, non-cocoa producers were found to be the worst-off group.

Recent analysis from the World Bank (1991) suggests that trends in agriculture (terms of trade as well as production) point towards an increase in rural incomes since 1984-85. Thus, "....since 1985 the rural terms of trade (food/non-food CPI) has remained stable in spite of a substantial rise in cereals output. In the case of cocoa, the rural terms of trade (cocoa producer price/non-food CPI) improved sharply between 1984 and 1987. Since then there has been a decline, reflecting the drop in international prices," (World Bank, 1991; brackets added).

The implications of these changes need to be treated with caution, however, in view of the economic structure of rural Ghana and the distribution of income. To take a case in point, most of the rural population is engaged in small-scale subsistence food production which explains why only 20 percent of all crop sales by poor farmers is accounted for by cocoa (Boateng et. al., 1990). As a consequence, it is possible to accept that rural incomes have increased while still questioning the distribution of that increased income. Thus, Alderman

(1991) states that "....using the data in Boateng et. al.....as well as the real increase in producer payments," the estimated effect of increased producer prices for cocoa would amount to only 2.8 percent of the total income of the extreme poor. Furthermore, since northern Ghana does not grow cocoa, it would appear that "....the hard core poor in the rest of the country had an increment to their income of about 4 percent, while the residents of the savannah benefited from this aspect of the recovery program, if at all, through increased employment for migrants," (ibid).

It appears evident, therefore, that poverty is still a significant problem in Ghana. It is principally a rural phenomenon and most prevalent among those who are outside or only marginally integrated with the cash or market economy.

II. FOOD PRODUCTION AND PRICES

According to Alderman (1991), there appears to have been a downward trend in food prices in both the pre- and post-adjustment periods (1970-82 and 1984-90). There was, however, an acceleration in the trend after 1984 for all commodities except rice and yams which Alderman attributes to better weather, increased yields and improved transportation.

While these findings are encouraging, there remain a number of major problems with food production. To take a case in point, although the annual growth rate of food production increased between 1983-87, for a number of items - rice, maize, plantain and cocoyam - net production (after adjusting for seed requirements, feed and post-harvest losses), was still below demand in 1987. Moreover, uneven progress has been made in recent years in meeting a greater proportion of demand locally for the domestically produced cereals. Thus, the self-sufficiency ratio for millet and sorghum was actually lower in 1988 than 1985, the reverse being true for rice and maize. Partly as a consequence of this situation, Ghana annually imported cereals equivalent to about 10 percent of requirements between 1985 and 1987.

Food production is also hampered by structural impediments such as low productivity; dependence on rain-fed agriculture; weaknesses in the delivery of agricultural services; and an inadequate and inefficient food storage and distribution system. The problems with the latter include the poor condition of roads, high fuel costs, frequent shortages of spare parts and poor maintenance of vehicles, a weak marketing infrastructure, and substantial post-harvest losses due to insufficient storage facilities and wastage during storage.

Last but not least, it is noteworthy that over 80 percent of farms in Ghana are used either solely or mainly for subsistence production with a higher proportion committed to cash crops in the south (MOA, 1986). Food production is mainly undertaken by smallholders, especially women, using traditional techniques of hoe and cutlass and family labour. The main obstacle to the adoption of new technology is the lack of access to information, credit, input supplies and marketing. Moreover, higher levels of food production will be difficult to achieve without substantially greater sensitivity towards and action on the needs of women in agriculture. This would require a significant reorientation of agricultural policy which is currently geared more towards cash crop production which is primarily a male activity. Thus, "....although cocoa contributes to only 15 percent of agricultural GNP, it received over 75 percent of public current expenditures on agriculture in the 1989 budget. Much of that disparity was due to the operating costs of the Cocobod. Expenditures on extension for cocoa were, nevertheless, four times those reported for the rest of agriculture....Forty-four percent of total government research expenditures were devoted to cocoa," (Alderman, 1991).

III. FOOD SECURITY

Despite recent improvements in some social and economic indicators, significant numbers of Ghanaians remain food insecure: small-scale subsistence food producers, migrant labourers and petty traders/producers in the informal sector, especially in urban areas. In terms of gender, women are by far the more vulnerable group, a situation which negatively affects children as well.

While increases in food production and the downward trend in food prices are encouraging developments, there are still a number of important obstacles to ensuring adequate food availability (as mentioned in section II above). In view of these constraints, the projections of the Medium-Term Agricultural

Development Programme (1991-2000) suggesting annual increases of 4 percent in food production appear to be somewhat optimistic. While such rates of increase have been recorded in recent years, they have been achieved within the context of significant fluctuations in the growth rate of non-cash crop production (classified as "agriculture, livestock and fisheries"); the range is between -1.3 percent (1985) and +5.8 percent (1988), (World Bank, 1991).

The impact of economic recovery on the entitlements of vulnerable groups also remains unclear. It appears as if net purchasers of food, especially those in urban areas, have benefited from increases in food production and a decline in prices. Nevertheless, this positive development does not address the fundamental causes of food insecurity in urban areas, that is, un- or under-employment, low productivity and unstable incomes. Some improvements may have been registered in this regard, however, due to the multiplier effects of gains in the formal sector on those employed in the much larger and related informal sector. In rural areas, farmers engaged in cash crop production, principally cocoa, have benefited from favourable terms of trade vis a vis food crops. In addition, the minority of farmers producing food for the market may also have gained, despite falling prices, because of increases in yields. On the other hand, it is possible to assert that small-scale subsistence food producers have yet to participate fully in the process of economic recovery. Their low productivity and limited access to off-farm employment as well as technology, credit and information continues to make them vulnerable to changes in external factors such as the weather. Hence, as data from Alderman (1991) suggests, changes in agricultural terms-of-trade have only marginally affected those areas in which most of the country's poor are concentrated and where food insecurity is most pronounced.

The issues of food availability and entitlements discussed above suggest that food insecurity remains a problem in Ghana. This is demonstrated, for example, by the phenomenon of the "hungry season", during the period immediately preceding the harvest, when food stocks are lowest and employment opportunities most limited. Food insecurity was also revealed by the emergency which occurred in the Upper East Region in 1991 due to poor weather and subsequent sharp falls in food production.

IV. SOCIAL AND ENVIRONMENTAL SERVICES: FINANCING, COVERAGE AND QUALITY[1]

In line with the crisis in the Ghanaian economy in the seventies and early eighties, expenditures on social services declined considerably. There has, however, been a noticeable improvement since the adoption of the Economic Recovery Programme (ERP) in 1983 but significant problems still remain to be tackled.

As a case in point, even though education expenditure as a proportion of total public expenditure was high in 1989 (24 percent), expenditure as a proportion of GDP was lower than the level achieved in 1960 - 3.5 percent versus 3.9 percent, (communication from the PAD/MFEP, 1992; World Bank, 1991). The growth in expenditures has been paralleled by greater emphasis on cost recovery through the institution of or increase in textbook and boarding fees at all but the lowest (that is, nursery) levels and the reduction, in real terms, of boarding and feeding subsidies. The effect of this on the cost of education suggests that schooling may be becoming less affordable for poorer groups leading to drop-out, especially among females.

Other constraints in the education sector include the uneven distribution of facilities and resources between rural-urban areas and regions; the inadequate provision of supplies and equipment; a high proportion of untrained teachers; problems in human resource policy and management; and weak, though rapidly improving, systems for the collection, analysis and utilization of data.

With regard to the health sector, expenditure as a proportion of GDP and public expenditure remained more or less constant during 1985-89: between 1.1 and 1.5 percent and 8 and 9 percent, respectively, (MFEP, 1991). More recent information, however, suggests that health expenditure as a proportion of GDP may have reached 2.4 percent in 1990 (MOH, 1991). With regard to health expenditure per capita, it rose in nominal terms from 542 cedis in 1986 to 812 cedis in 1988 and 1737 cedis in 1990 (ibid). Nevertheless, real per capita

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1. These issues are covered in greater detail in the various sectoral programmes presented in Chapter Four.

expenditure (1986 prices) increased only marginally between 1986 and 1990 (ibid). Within health expenditure, allocations for PHC were under-budgeted, constituting about a third of the Ministry of Health's budget in 1990 (ibid). As a result, in part, of this situation, the coverage of health services is only 45 percent in rural areas compared to 92 percent in urban areas, yielding an overall coverage rate of 60 percent nationally.

There are also some major structural problems in the health system such as the centralization of operations; limited community participation in the planning and delivery of services; unclear links between functional responsibilities and financial and administrative authority, especially at the district level; weak planning, monitoring and evaluation systems; insufficient attention to manpower planning and human resource management; disparities in the distribution of facilities and personnel between rural-urban areas and regions; and low utilization of services.

As for the key environmental services - housing, water and sanitation - responsibility is fragmented amongst several agencies such as the Ministries of Health, Works and Housing and Local Government, the Environmental Protection Council (EPC) and the Ghana Water and Sewerage Corporation (GWSC). The absence of a coordinating framework has detracted from the effectiveness of interventions.

As a result of past policies and practices, the coverage of environmental services is low. For example, in the case of urban housing, an average annual delivery rate of 133,000 units will have to be achieved over the next 20 years to cope with accumulated deficits as well as meet the needs of a growing population. This requirement compares with the current average annual supply of 28,000 housing units which yields a performance rate of only 21 percent (MWH, 1987b).

With regard to safe water supply and sanitation, there is significant uncertainty about the actual coverages. According to the MWH (1991), it appears that "....30% of the rural population has had an improved water supply system (handpump or piped) installed in their community during the last 20 years." Nevertheless, given intermittent piped service and the inoperability of about 30 percent of the handpumps in the country, the rural service coverage may be as low as 20 percent (ibid). A different set of figures for safe water supply are provided by Dovlo (1990) who states that by the end of the IDWSS, coverage in urban areas had remained unchanged at 93 percent but had expanded considerably to reach 50 percent of the rural population, implying a national coverage of about 63 percent. The GLSS (1989), on the other hand, estimates that in 1987-88, the national distribution of households by source of drinking water was as follows: inside plumbing - 11.9 percent; water vendor or truck - 3.3 percent; natural sources - 51.9 percent; other sources - 33 percent. These averages conceal substantial disparities within rural areas and between rural-urban areas and regions.

V. WOMEN'S STATUS AND ROLE IN SOCIETY

Women are critical to human development in Ghana. For instance, there are indications that a growing number of households are headed by females. This implies that strategies for increasing employment and incomes and, therefore, reducing poverty must be adapted to this emerging reality if they are to be successful. At the same time, approaches and interventions designed to improve the health and educational status of the population must recognise that the key "change agent" in this process will increasingly be women. Thus, their needs, attitudes and behaviour will have to be addressed as central concerns in social development. Seen from another perspective, women will be crucial to the achievement of targets for agricultural growth and food security.

There are, however, numerous obstacles to recognising and building upon the contributions of women. These include the gender insensitivity of policy and programme formulation and monitoring; inappropriate regard for the institutional structures needed to reach women effectively; the absence of initiatives to close the gender gap in education and employment; insufficient recognition of women's rights in legislation; poor enforcement of those rights which are already recognised; and ingrained negative social and cultural attitudes and behaviour towards women. The challenge for the country is to address these constraints, for without the active participation of women, important national goals will remain statements of hope rather than a record of achievement.

VI. SIZE, GROWTH AND AGE STRUCTURE OF THE POPULATION

The population of Ghana is currently estimated at about 15.7 million and is expanding at an observed annual rate of 2.6 percent though estimates suggest that the growth rate may now be 3.1 percent per annum (GSS). A significantly higher population growth rate (3.4 percent) has been estimated by the United Nations Centre for Population Studies. As for the future, the World Bank (1989a) projects a growth rate of 3 percent per annum for the period 1987-2000. Of the total population, 70 percent are presently located in rural and 30 percent in urban areas.

Rapid population growth results from a high fertility rate which contributes to a young population (48 percent under 15 years of age) and also adversely affects the health and survival of women and children. Furthermore, attainment of food security and the provision of social services as well as productive employment for a growing population has proven difficult and will continue to prove problematic in the future, given limited national resources and the low productivity of important sectors of the economy.

It has been evident for some time to planners and policy-makers that the current and future stream of income from economic growth are being minimised by a growing population. The prospects are sobering: at prevailing rates of population and economic growth, it will take Ghana more than 30 years to double per capita income (leaving aside the more complex issue of changes in the distribution of income).

VII. INTERNAL AND EXTERNAL MACROECONOMIC CONSTRAINTS

These include: low rates of savings and investment, particularly in the private sector; a persistently high inflation rate; sharp reversals in the terms of trade which fell by 29 percent in 1987/88 and another 15 percent in 1988/89; relatively high, though falling, levels of debt servicing which peaked at 68 percent (of exports of goods and services) in 1988 before decreasing to 38 percent in 1990 and an estimated 30 percent in 1991 (MFEP, 1992); and an uncertain aid and foreign investment climate due to changes in Eastern Europe which are increasing demands on a limited pool of resources. To illustrate the impact of external factors, Ghana's dependence on the taxation of primary commodity exports implies that adverse movements in the terms-of-trade can directly influence the level and stability of public expenditure from year-to-year. Volatility in commodity prices, therefore, impedes sustained investment, disrupts the availability of public services and destabilises economic activity.

CHAPTER TWO

The Broad Framework for Action:
A Human Development Strategy for Ghana

I. INTRODUCTION

The conceptualisation and content of "development" and development policy has undergone a continuous process of evolution in the past half-century. The 1980s and early 1990s, in particular, have witnessed an intensive reassessment of past development experience and strategies, influenced in large measure by economic crises in many parts of the Third World and by rapidly changing global political and economic conditions. These changes have been reflected, among other things, in ideas which have now come to be widely recognised such as "structural adjustment", "adjustment with a human face" and, most recently, "human development".

The intellectual thrust of these ideas may be simplified into four major points. First, it has been argued that markets and open trade regimes must constitute the underpinnings for economic efficiency and sustained growth. Second, and partly in response to the preceding ideas, emphasis has been laid on acknowledging and dealing with the social costs of structural change, especially as they affect the poor and vulnerable such as women and children. Third, it has been suggested that the concept of "development" should be extended beyond its economic dimensions to encompass, as its meaning and ultimate objective, improvements in the quality of life of people. Finally, there has been a recognition that individual programmes and projects, such as those designed to reduce poverty or increase agricultural production, cannot be pursued successfully without a supportive framework of development policies.

Ghana has been actively involved in this dialogue as a practitioner of the changing development philosophy of the 1980s and 1990s. It was amongst the first sub-Saharan African countries to launch far-reaching economic, social and institutional reforms in response to deepening crisis in the economy and society. Some of the adverse effects of reform were also addressed through PAMSCAD, once again a pace-setter in the region. Most recently, the Government has been examining the future direction of long-term development policy. One of the key measures in this area has been the launching of a Human Development Initiative (HDI) in the country.

It is against this background that the National Development Planning Commission's Cross-Sectoral Planning Group for Human Development (CSPG-HD) prepared a policy document entitled "Making People Matter: A Human Development Strategy for Ghana", (NDPC, 1991). This document outlines a comprehensive, human-centred development strategy and policy framework which consolidates and builds upon current development efforts (see section III for details).

The preparation of a Human Development Strategy (HDS) constitutes only one stage in the national development planning process and represents the intermediate level of inter-sectoral coordination within the broad field of human development. The HDS will be supported by strategies, which are currently under preparation, on the economy, spatial organisation of development and the environment. The rationalised and coordinated strategic frameworks will constitute the National Development Policy Framework (NDPF) which will provide the basis for the preparation of medium and long-term perspective plans by functional agencies, sectoral ministries and districts. The NDPF will also be made available to NGOs and the private sector.

II. UNDERSTANDING HUMAN DEVELOPMENT

Some fundamental and revealing questions are often not asked in the fast-paced and technocratic world of policy-making: <u>what is the purpose of development</u>? What ultimate benefit is to be derived from attaining economic growth, expanding the provision of basic services, increasing agricultural production, reducing the population growth rate and so on? Are they ends in themselves?

"Human development" represents a powerful response to these questions. It is a concept which defines both the purpose and process of development. Thus, the <u>goal</u> of human development is to enlarge "....people's choices. In principle, these choices can be infinite and change over time. But at all levels of development, the three essential ones are for people to lead a long and healthy life, to acquire knowledge and to have access to the resources needed for a decent standard of living....Additional choices highly valued by many people, range from political, economic and social freedom to opportunities for being creative and productive, and enjoying personal self-respect and guaranteed human rights," (UNDP, 1990). The <u>process</u> of human development,

therefore, entails both "....the formation of human capabilities - such as improved health, knowledge and skills - and the use people make of their acquired capabilities - for leisure, productive purposes or being active in cultural, social and political affairs," (ibid). In short, human development is concerned with people - how they participate in and benefit from development.

It is important, however, not to confuse human development with human capital formation or human resource development. *The latter "....view human beings primarily as means rather than as ends...."* (ibid), treating people as inputs into production. While it is true that "....human beings are the active agents of all production...." they are also "....the ultimate ends and beneficiaries of this process," (ibid). As a consequence, human capital formation or human resource development must be seen as only one aspect of human development.

III. A HUMAN DEVELOPMENT STRATEGY (HDS) FOR GHANA[2]

The HDS for Ghana has been prepared in response to challenges which call for the articulation of an alternative development strategy with a more human-centred focus. These challenges include the following:

"(a) The need to change the logic of development policy-making, since the methodology and process of defining policies and programmes are important determinants of actual outcomes;

(b) The resolution of the problem of disparity, particularly between genders, regions and social classes; and

(c) Decisive measures to incorporate appropriate environmental management practices in the development process.

Other critical considerations of the strategy....include the institutional framework for the management and administration of the national economy, particularly, the transparency, efficiency and accountability of the public administration system, effective decentralisation and maximization of the complementarities that exist between the public and private sectors, including non-governmental organisations," (pp. 23-24).

On the basis of an assessment of achievements and disappointments over the past decade of development in Ghana as well as the scope and significance of an array of unmet needs, the HDS has "....identified eighteen multi-sectoral goals which define thematic areas for intervention and action. These are:

- improved educational achievements for all;
- improved health for all;
- improved nutrition for all;
- national food security achieved;
- access to and coverage of potable water improved;
- sanitation improved;
- housing improved;
- rate of population growth reduced;
- sustained growth achieved;
- more efficient, broadened revenue base established;
- more efficient public administration system established;
- private sector participation increased;
- productive employment increased;
- productivity increased;
- social security system broadened;
- social, economic, political and spatial disparities reduced;
- access to information and communication increased; and
- transportation system improved," (pp. 9-10).

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2. The following section is based on verbatim extracts from "Making People Matter," (NDPC, 1991).

The core of the HDS, which outlines the broad actions which need to be undertaken to achieve these goals, has been shaped by several major strategic concerns. These include the "....promotion of rural development and the enhancement of conditions for women. Other major concerns are improvement in urban living conditions (especially with regard to the poor); reinforcement of mechanisms for participatory development; and protection of the environment. In addition, there are.... critical factors that form part of the strategy and underpin it. These are the consolidation and reinforcement of an enabling macroeconomic environment; and the establishment of mechanisms to protect gains and maintain momentum in human development in the event of unforeseen shocks," (p.25).

Taking into account the policy challenges, the broad goals for human development and the areas of strategic concern discussed above, the HDS proposes sub-strategies to guide specific actions in individual programme areas. These sub-strategies include:

" Strengthening co-ordination and collaboration between sectoral ministries, districts, NGOs and other agencies that are involved in the planning, programming and implementation of human development programmes.

Strengthening management capacity of central and local government and of those decentralized public agencies responsible for development and delivery of public services with a view to improving the efficiency and effectiveness and expanding the coverage of these organizations.

Promotion of investment in basic social and economic infrastructure, particularly by the private sector and especially in rural areas.

Promotion of local level authority and control over the provision of basic services.

Promotion of effective delegation and divestiture of responsibilities for management of appropriate services....to the private sector, including NGOs.

Provision of adequate funding for social sector programmes at both national and local levels and implementation of measures to ensure that funds are released for approved programmes.

Improvement of revenue collection at national and, more especially, sub-national levels.

Strengthening capacity of central and local government to formulate policies and plans as well as monitor implementation of social programmes to ensure balanced and equitable provision and access to basic services.

Promotion of community participation and involvement in the decision-making, management and supervision of social services," (p.29).

IV. THE RELATIONSHIP BETWEEN THE HDS AND THE NATIONAL PROGRAMME OF ACTION

There is a strongly symbiotic relationship between the HDS and the NPA. Three dimensions of this relationship are particularly noteworthy. Firstly, it will have become apparent from the preceding sections and will become even clearer in subsequent chapters, that the two initiatives are entirely consistent with each other. They share common goals, concerns and strategies, whether general or sector-specific. Thus, the nine major goals of the NPA which are elaborated upon in Chapter Three represent a quantitative formulation of some of the key goals described in general terms in section III above.

Similarly, the strategies proposed in the individual sectoral programmes in Chapter Four reflect many of the sub-strategies of the HDS. They emphasise improved targeting in terms of disadvantaged groups and regions as well as the least developed components of basic services, to reduce disparities; decentralisation of service planning and delivery; significant investment in capacity-building at the district level; intensified involvement of communities in implementation, monitoring and supervision; a broadening of resource

mobilisation to include communities, NGOs and the private sector in addition to the Government and donors; increased efficiency in resource allocation and use; expanded physical accessibility to basic services; and improved coordination and collaboration within and among the public and private sectors.

Secondly, the NPA may be seen as the concrete expression of the social aspects of the HDS. The former provides a unique opportunity to translate the general social concerns of human development in Ghana, especially as they relate to children and women, into specific programmes and projects. Moreover, the financial implications of such initiatives have been considered and feasible resource mobilisation strategies identified. This means that the considerable delays sometimes encountered in translating priorities into budgetary allocations and, subsequently, improvements for the target population can, to a significant extent, be circumvented. There will, therefore, be less distance to cover from rhetoric to reality.

Finally, past experience in Ghana and abroad has clearly demonstrated that isolated programmes and projects cannot be effective nor can their long-run impact be sustained without a supportive framework of development policies. For example, the benefits of protecting infants through immunisation would be wasted if this only prepared them to cope, at an older age, with all the debilitating effects of unemployment or under-employment, declining real incomes, unavailable or inadequate basic services, unaffordable and poor housing and a deteriorating natural environment. The inter-relationship between the NPA and HDS addresses this issue by ensuring that sector-specific interventions are buttressed by broader development policies whether economic, financial, social, political, cultural or institutional. This will help to guarantee that the improvements made in the lives of Ghanaian children will be lasting achievements rather than fleeting successes.

CHAPTER THREE

The Outline of a Better Future for the Ghanaian Child: Goals for the Year 2002

THE OUTLINE OF A BETTER FUTURE FOR THE GHANAIAN CHILD: GOALS FOR THE YEAR 2002[3]

I. THE CHALLENGE AHEAD

The "snapshot" provided by the situation analysis (Chapter One) clearly portrays the difficult conditions confronting children and women in Ghana. Many, if not all, of these problems can be minimised and, in a number of cases, even eliminated through determined efforts. Undertakings of this nature would not necessarily require vast amounts of additional technical, material or human resources: experience in the 1980s has convincingly demonstrated that impressive progress can be made through technologically simple, targeted and cost-effective interventions (see Chapter Four). Under these circumstances, it would be an abdication of our responsibilities to children and, indeed, to the future of Ghana, if we failed to take action when the need is so pressing and the potential for achievement so great.

II. MAJOR GOALS FOR THE WELL-BEING OF GHANAIAN CHILDREN AND WOMEN

In view of the global situation and the position of Ghana therein, learning from the situation analysis of children and women, taking into account historical rates of change in human indicators, having regard to the concerns expressed in the Human Development Strategy and aware of Ghana's commitments as a signatory to the Declaration and Plan of Action of the World Summit for Children and in line with the medium- and long-term plans of the government, the following major goals for the year 2002 are proposed[4], based on estimates for 1991 (relevant sectoral goals are given in the Sectoral Programmes of Action in Chapter Four):

a. Reduction of the Infant and Under Five Mortality Rates (IMR/U5MR) by 35 percent, from 77 to 50 per thousand live births and 155 to 100 per thousand live births, respectively.

b. Reduction of the maternal mortality rate by a third.

c. Reduction of severe and moderate malnutrition among children under 5 years of age by 50 percent.

d. Universal access to basic education and completion of primary education by at least 80 percent of children in the relevant age-group (6-11 years).

e. Reduction of the female illiteracy rate (among those 15 years of age and above) by 50 percent.

f. An increase in the coverage of safe water supply to 90 percent of the rural population (by the year 2010).

g. An increase in the coverage of facilities for sanitary means of excreta disposal to 90 percent of the rural population (by the year 2010).

h. Reduction in the proportion of children in especially difficult situations.

i. Widespread acceptance and observance of the Convention on the Rights of the Child.

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3. The year 2002 has been chosen because of the ten-year duration of the National Programme of Action, assuming 1993 to be the first year of implementation.

4. There are two exceptions to this common deadline as is evident below: objective (f) reflects national policy while the related objective (g) is designed to be consisted with the target for safe water supply.

Intermediate targets for 1997, midway through the decade-long Programme of Action, would be as follows:

a. Reduction of the Infant and Under Five Mortality Rates (IMR/U5MR) by 17.5 percent to 63 per 1000 live births and 128 per thousand live births, respectively.

b. Reduction of the maternal mortality rate by 16 percent.

c. Reduction of severe and moderate malnutrition among children under 5 years of age by 25 percent.

d. Increase in primary school enrolment to 80 percent of the relevant age group (6-11 years) and completion of primary school by at least 60 percent of children in this age-group.

e. Reduction of the female illiteracy rate (among those 15 years of age and above) by 25 percent.

f. An increase in the coverage of safe water supply for the rural population by 20 percent of the targeted expansion to the year 2010. **[quantification on actual changes in coverage will depend on the results of proposed surveys]**

g. An increase in the coverage of facilities for sanitary means of excreta disposal for the rural population by 20 percent of the targeted expansion to the year 2010. **[quantification on actual changes in coverage will depend on the results of proposed surveys]**

h. Reduction in the proportion of children in especially difficult situations.

i. Widespread acceptance and observance of the Convention on the Rights of the Child.

IMPORTANT ASSUMPTIONS

The following assumptions are critical for the achievement of stated objectives. If they are not satisfied, then the objectives of the NPA may not be realised as planned.

a. Strong and sustained political commitment to the implementation of the NPA.

b. Entrenchment of the Convention on the Rights of the Child in the Constitution of Ghana.

c. Successful implementation of the policy of decentralization.

d. Equity in the distribution of development resources among and within regions.

e. No major natural or man-made disasters.

f. Continued international co-operation in support of Ghana's economic recovery.

CHAPTER FOUR

Sectoral Programmes of Action

Population, Health and Nutrition (PHN)
Education
Water Supply and Sanitation (WS/S)
Children in Especially Difficult Situations (CEDS)
Advocacy

POPULATION, HEALTH AND NUTRITION (PHN) PROGRAMME

1. Background

1.1 The Problem

The situation analysis (Chapter One) has clearly outlined the poor health and nutritional status of children and women in Ghana. To reiterate some of the salient points, the under-five mortality rate (U5MR) is 155 per 1000 live births (GDHS, 1989). This is an unacceptably high rate. The tragedy is that almost 60 percent of deaths in this age group are due to preventable causes (measles, pneumonia, low birth-weight, malaria, anaemia, diarrhoea, severe malnutrition and tuberculosis). Some of the latter causes especially malaria, diarrhoeal diseases, acute respiratory infections (ARI) and measles are also responsible for morbidity among children.

Frequent and prolonged illness is, in addition, closely related to the prevalence of malnutrition in Ghana, both as cause and effect. Data from the National Nutrition Survey (NNS,1986) showed, for example, that almost 60 percent of children 0-60 months of age were below 80 percent of the US-NCHS weight-for-age standard, twice the level reported in the first NNS in 1961-62. More recent surveys suggest a notable improvement in nutritional status although the situation continues to remain serious. An analysis by Alderman (1991), based on data from the GLSS (1989) and using the same standards as the NNS, found that, among children under five years of age, 31.4 percent were underweight.

In the case of women, the maternal mortality rate (MMR) ranges between 5-10 per 1000 live births. The leading direct cause is haemorrhage followed by infection and pregnancy-related hypertensive diseases. These problems are the consequence, to a large extent, of the lack of supervised deliveries - only about half of all deliveries are supervised (GDHS, 1989) - and pre-natal problems such as malaria and anaemia. It has been estimated that approximately 40 percent of maternal deaths are preventable. Pregnancy-related conditions as well as diseases which are water-borne and/or associated with poor environmental sanitation are some of the principal causes of morbidity among women. As with children, the poor health status of women, especially pregnant women, is reinforced by and contributes to high levels of malnutrition. Thus, among women tested at pre-natal clinics in 1990, 71 percent were found to be anaemic by WHO standards (MOH, MCH/FP, 1990). To make matters worse, a high total fertility rate, estimated to be 6.4 in 1988 (GDHS, 1989), exacerbates the effects of maternal malnutrition.

The precarious lives of children and women described above reflects, to a significant degree, high levels of illiteracy among women (77 percent among those 9 years and older) and low levels of awareness of beneficial health, hygiene and nutritional practices. Some cultural factors, for example, relating to a preference for large families or to feeding practices and food taboos also have an adverse effect. Nevertheless, the chief constraining factor not surprisingly is poverty which is made worse by and worsens the impact of poor health and nutritional status and high fertility. This combination of factors leads, for example, to the limited coverage of immunisation, inadequate and insufficient food intake and the very low proportion of currently married women (just 5 percent) using modern methods of contraception.

Beyond socio-economic, religious and cultural factors, serious shortcomings within the health system remain a major constraint to a sustained improvement in health and nutritional status and a rapid reduction in the fertility rate (see below for a description of policies and structures). There are several weaknesses from an organisational viewpoint such as the absence of an approved policy framework on nutrition, contrary to the situation in the areas of health and population planning; the inconsistency between an emphasis on decentralised operations and the reality of centralised management; as an inevitable corollary of the latter, a low level of community involvement in the provision of health services; insufficient integration of services in planning and organisation and at the point of delivery - verticalisation is still the norm; weaknesses in logistics and maintenance; the paucity of data on key operational and impact indicators, reflecting the absence of a functioning and relevant health information system as well as a limited capacity for monitoring and evaluation; a persistent curative orientation to health management as shown, for instance, by the professional qualification

of health administrators and the medical as against paramedical curricula of academic programmes; and, associated with the preceding point, insufficient attention to human resource planning and management including issues such as training and conditions of service.

With regard to health service availability and utilisation, significant "....disparities exist in the distribution of facilities and human resources between rural-urban areas and regions; use of facilities and services tends to be low due to insufficient health awareness and ignorance about their importance...." while "....the effect of cost recovery on the poorest....is still not fully understood," (GOG/UNICEF, 1990). In 1989, the coverage of health services stood at 60 percent nationally, representing 92 and 45 percent coverage for urban and rural areas, respectively.

A reduction of these deficiencies is, however, constrained by the unbalanced pattern of inter- and intra-sectoral allocations of budgetary resources. In 1989, central government funding of health care amounted to 2.4 percent of GDP (MOH, 1991). The health sector's share of the government's capital and recurrent budgets was only 6 and 11 percent, respectively, in 1990. The situation may be worse since budgetary allocations are often not matched by actual releases of funds. Thus, only 33 percent of budgeted estimates were actually released for expenditure in 1991. Compounding matters even further, about 70 percent of the MOH's budget is spent on curative care (MOH, 1991), primarily benefiting the 30 percent of the national population living in urban areas.

1.2 Government Policies and Structures

Ghana prepared a strategy paper on primary health care (PHC) as long ago as 1976. This paper was subsequently revised in 1978 and further developed in 1982 as the New Health Policy (NHP). The principal objective articulated in these policy statements has been to provide health care to 80 percent of the population by 1990, using a district and sub-district level PHC system (see below for details). Within PHC, the policy for maternal and child health/family planning (MCH/FP) aims at making integrated health services available to all children and women. Recent initiatives in the health sector include the rehabilitation and upgrading of physical infrastructure, the preparation of a national formulary and essential drugs list and the launching of community- and health facility-based drug revolving funds, using the Bamako Initiative and "cash-and-carry" approach, respectively. The community-based funds are being established in five districts and will be extended to an additional five by 1995. With regard to the "cash-and-carry" system, health facilities are allowed to retain 100 percent of the fees collected from patients for the provision of essential drugs. These funds are to be used to establish revolving funds for replenishing drug supplies by direct purchase from district, regional and national medical stores operated by the health administration at that level.

As mentioned earlier, the country is finalising a food and nutrition policy, first drafted in 1984. The draft document deals with issues of "....food production, storage, processing, marketing and consumption, food and nutrition surveillance, nutrition education and local weaning food production/promotion, control of specific nutritional disorders, and supplementary feeding," (GOG/UNICEF, 1991). Related to the latter policy, one of the principal objectives of the recently formulated Medium-Term Agricultural Development Programme (MTADP, 1991-2000) is to "....provide all Ghanaians with food security by way of adequate nutritionally balanced diets at affordable prices both now and in the future." The Ministry of Agriculture (MOA) hopes to realise this objective by, inter alia, encouraging the growth of smallholder food production through adoption of appropriate technology; increasing food processing; strengthening extension services; rehabilitating and expanding silos to expand storage capacity; providing necessary inputs; and constructing feeder roads (MOA, 1990).

Ghana first articulated its population policy in 1969, becoming one of the pioneers in this area in sub-Saharan Africa. This policy was reviewed at the Conference on Population and National Reconstruction held in 1986 as well as the National Population Conference in 1989. The latter were expected to set the stage for accelerated efforts to reduce the rapid rate of population growth (currently estimated at 3.1 percent per annum). A number of recommendations were also made at both Conferences, reflecting the view that the thrust of the original population policy was still valid and should be implemented, albeit with greater emphasis on issues relating to the environment. In addition, a call was made for restructuring population programmes under the

leadership of a National Population Council. It was also proposed that a secretariat be established at the MFEP to service the Council. Other recommendations were for increased research into fertility and population issues and for the mobilisation of resources for programme implementation.

In terms of the organisation of the governmental health system, it centres around a three-tiered structure designed for the provision of primary health care. The lowest tier in this structure is Level A or the community where a two-member team of health workers, chosen and paid by the community, is "....responsible for preventive and promotive care and for simple curative measures. Emphasis is given to pregnancy management, child health promotion and environmental health," (MOH, 1991). The next tier in the system is Level B or the health centre/post where a four-member team is "....responsible for the primary level of non-specialised curative care of patients referred from Level A, including the diagnosis and treatment of these patients. They also undertake the provision of MCH services, including the identification of pregnant women at high risk, and routine immunizations for mothers and children....Level B staff have additional responsibilities for the technical supervision of community health workers from Level A. Their other functions include health education, water and food protection, and communicable disease control activities," (ibid).

The final tier in the structure is Level C or the district which is the "....key unit for the operation of primary health care in Ghana. The District Health Management Team (DHMT) coordinates all health activities at the district level...." and has "....responsibility for planning, managing and implementing the entire government and non-governmental district health services, including the management of resources and manpower, and the supervision of Level B staff throughout the district," (ibid).

The DHMTs are assisted in their work by the regional health administrations which have been tasked to "....translate central policy into district action by providing support in the form of guidelines, protocols and procedures, to ensure coordination between districts, monitor district programme implementation and to provide feedback to districts and the national headquarters," (ibid). Finally, the national level is currently being reorganised to focus on essential supportive functions. These include "....developing broad policy guidelines; formulating national plans and budgets; developing policies and plans for human resource development; mobilizing resources for health; coordinating donor assistance; supplies management; coordinating research; fostering inter-sectoral collaboration; and monitoring policy implementation," (ibid).

1.3 Non-Governmental and Donor Involvement

Approximately 300 NGOs are involved in the PHN sector (World Bank, 1990a). These include both nationally-based and international organisations such as the Christian Health Association of Ghana, Adventist Development and Relief Agency, Canadian Public Health Association, Catholic Relief Services, International Planned Parenthood Federation, Jaycees International, Rotary International, Save the Children Fund and World Vision International. Although up-to-date information on the contributions of the non-governmental sector are not available, in 1987, the services performed by NGOs "....were valued at more than C2.6 billion, or about half of MOH's own recurrent expenditures. Of this, C600 million was financed through government subvention of health staff salaries, and at least half by foreign donations....Mission hospitals now account for 30% of hospital beds and inpatient admissions in Ghana. In 1987, they provided 35% of outpatient care," (World Bank, 1990a).

With regard to the donor community, the multilateral contributors to the health sector during 1984-90 included the African Development Bank, the EEC, UNDP, UNFPA, UNICEF, WHO and the World Bank/IDA (MOH, 1991). The bilaterals included Canada, Germany, Japan, Netherlands, Switzerland, the United Kingdom and the United States (ibid). Total donor assistance during this period amounted to $65.5 million, composed of $23.3 million in multilateral and $42.2 million in bilateral assistance (ibid). Moreover, major commitments have been made for activities up to the mid-1990s (World Bank, 1990a). In the case of multilaterals, this has involved, among others, the African Development Bank ($18 million for hospital rehabilitation), UNFPA ($10 million for family planning, safe motherhood), UNICEF ($10 million for EPI/ORT, district PHC development, food and nutrition policy, control of IDD, safe motherhood) and the World Bank ($27 million for PHC, family planning, institutional and manpower development, procurement/ supply). Commitments from bilaterals include the following: Canada - $2.6 million (drugs, EPI); Germany -

$6.3 million (pharmaceuticals); Italy - $1.2 million; Japan - $2.0 million (NMIMR); Saudi Fund -$9.2 million (new health stations); United Kingdom - $1.2 million (operations research); and USAID - $35 million (family planning, safe motherhood, AIDS control).

2. Programme Objectives

2.1 Principal Objectives

The objectives of the PHN Programme are designed to support the achievement of the relevant major goals for the year 2002 proposed in Chapter Three. The latter include: reduction of the IMR from 77 to 50 per 1000 live births, U5MR from 155 to 100 per 1000 live births and MMR from 5-10 to 3.3-6.6 per 1000 live births; and reduction of severe and moderate malnutrition among children under-five by 50 percent.

The principal objectives of the PHN Programme are to:

(a) Reduce the IMR attributable to preventable causes by 70 percent, from the current level of 48.3 percent to 14.5 percent;

(b) Reduce the Child Mortality Rate/CMR (1-4 years of age) attributable to preventable causes by 60 percent, from the current level of 64 percent to 26 percent;[5]

(c) Reduce the MMR attributable to preventable causes by 50 percent, from the current level of 42 percent to 21 percent;

(d) Reduce the incidence of teenage pregnancy by 50 percent; **[quantification will depend on the outcome of a baseline survey]**

(e) Reduce the rate of low birthweight (2.5 kg or less) from 24 to 10 percent;

(f) Reduce the incidence of immunisable diseases by 70 percent;

(g) Eradicate poliomyelitis;

(h) Eradicate dracunculiasis/guineaworm disease (by 1993);

(i) Reduce the prevalence of protein energy malnutrition (PEM) among children under five years of age by half (stunting, wasting, low weight-for-age);

(j) Reduce the prevalence of micronutrient deficiencies (iodine, vitamin A) among children under eighteen years of age and women of child-bearing age (15-44 years); **[quantification will depend on the outcome of on-going research]**

(k) Reduce the prevalence of anaemia among pregnant women by 50 percent, from 69 percent to approximately 35 percent;

(l) Increase the average birth interval to 3 years;

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5. The targeted reductions in preventable infant and child deaths will lead to the overall objective of a 35 percent reduction in both the infant and under-five mortality rates.

(m) Increase awareness on critical health, nutrition and family planning issues among at least two-thirds of the population; and

(n) Establish a fully operational and decentralised district health system (planning, budgeting, programme/project management, service delivery, monitoring and evaluation).[6]

2.2 Geographic Coverage and Target Populations

The PHN programme would benefit the whole population even though it will be primarily targeted at children under five years of age (0-4 years) and women of childbearing age (15-44 years), representing 3.0 and 2.8 million people, respectively (based on population estimates for 1992). The coverage objectives and target populations, both generally and with regard to specific services and indicators are described below. Thus, by 2002:

(a) Overall, the proportion of the population with access to health and nutrition services would rise to 85 percent from the current level of 60 percent, including 95 percent of the urban and 80 percent of the rural population;

(b) The proportion of schools with access to the national school health programme would reach 50 percent in 1994 and 90 percent by 1998;

(c) 90 percent of pregnant women would receive antenatal care (including screening for risk factors, malaria prophylaxis and provision of ante-natal drugs such as vitamin supplements);

(d) 80 percent of all births would be supervised by trained personnel (doctor, mid-wife, Traditional Birth Attendant/TBA);

(e) 30 percent of women-in-fertile age (WIFA) would use modern contraceptives;

(f) 90 percent of women of child-bearing age would receive five doses of the tetanus toxoid (T.T.) vaccine;

(g) 90 percent of children under one year of age would be fully immunized against the six immunisable diseases;

(h) 60 percent of diarrhoeal episodes among children under five years of age would be treated with oral rehydration therapy/ORT (including use of oral rehydration salts/ORS and homemade solutions);

(i) 80 percent of febrile episodes among children under five years of age would be effectively treated with anti-malaria therapy;

(j) 60 percent of children under 5 years of age with acute respiratory infection (ARI) would receive correct antibiotic therapy;

(k) The average breast feeding duration would be 18 months, with exclusive breastfeeding for the first four months of life;

(l) 50 percent of children under 2 years would have appropriate weaning diets; and

(m) 80 percent of children under 3 years would be weighed at least quarterly, with specific causes of poor growth being identified and appropriate treatment given.

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6. It should be noted that the attainment of objectives (e), (f), (g), (i), (j), (k) and (m) would also contribute to a reduction in the incidence of physical disability (see also the CEDS Programme).

3. Programme Strategies

The objectives of the PHN Programme would be achieved through an inter-locking set of strategies. They would include:

(a) Accelerated restructuring of the governmental health system: Despite stated intentions, Ghana has been unable to exploit the efficiency and equity gains from decentralisation. To comprehensively address this weakness, priority would be assigned to the timely completion of the on-going restructuring of the MOH; the delegation of authority for critical aspects of health management to the districts to match the responsibilities they have already been assigned, especially in the areas of programme planning, budgeting and expenditure and human resource management (see also (b) below); and the development of institutionalised horizontal linkages between communities, NGOs and the governmental health care system as well as other relevant public organisations (see also (g) below).

(b) Integrated planning and delivery of services within a decentralised, district-level health care system: The prevailing verticalisation of PHN programmes and projects leads to the fragmentation of services, inefficient resource use through duplication of delivery structures and reduced impact on target populations due to the narrow focus of interventions and the neglect of linkages between causal factors. To overcome this serious constraint, vertical interventions would be phased out and replaced by a programme approach at the planning level nearest to the target populations, that is, the district. This would entrench a planning process entailing a sequence of problem assessment, goal identification, strategy development and programme formulation. It would lead to a situation where an integrated set of interventions would be implemented through a common district-level service delivery structure to achieve a number of different but related objectives.

(c) Expanded physical access to health facilities (both public and private/NGO): The objectives of the PHN Programme require a significant expansion in the health infrastructure to increase the coverage of services and the frequency of contact between service providers and users. This would be achieved through a two-pronged approach: an expansion in the number of physical facilities, particularly in poorly-served areas; and an increase in the capacity of lower-level facilities (Levels B and C) to provide outreach services, thus, multiplying the impact of both existing and newly-established fixed facilities.

(d) Improved strategies for dealing with major health and nutrition problems: To be effective, the increased availability of integrated services would have to be matched by the identification and/or strengthening of technical strategies to cope with the key challenges presented by the epidemiological and nutrition profile of the country. Emphasis would be placed, among other things, on increased prevention, correct diagnosis and treatment, where feasible, at the sub-district level, prompt referral of high-risk cases to the appropriate tier of the health care system and improved monitoring of health and nutritional status to track the impact of services as well as provide early warning of emerging problems.

(e) Strengthened and reorientated support services for decentralised operations: A prerequisite for the successful operation of a decentralised, district-based health system would be the existence of supportive services at higher levels. This condition would be satisfied through expanded capacity as well as more efficient use of existing resources in four key areas: health planning and budgeting; human resource development and management; logistics and supply; and inter-sectoral coordination. This approach would be consistent with and help accelerate the on-going restructuring of the MOH.

(f) Increased efficiency in resource allocation and use: The current intra-sectoral breakdown of governmental health expenditure, which reflects a substantial bias towards curative care, constitutes an inefficient and inequitable use of scarce resources, given the rural-urban distribution of the population and the epidemiological profile of the country. The same volume of investment in preventive/PHC programmes would yield substantially greater returns in terms of, for example, reductions in child and maternal morbidity and mortality.

Since a large proportion of allocations are "locked into" the existing curative infrastructure, the aim would be to enhance the transparency and efficiency of future spending through three important measures: the publication of estimated figures for recurrent and capital expenditure on PHC, as part of the annual budget process; the allocation to PHC programmes of a dominant share of any additional resources, whether national or external, made available to the health sector; and, last but not least, the protection of essential health expenditures, especially in the area of rural and urban PHC, from arbitrary cuts or limits on spending.

(g) Enhanced sustainability of PHN services: The scale of effort required to realise the objectives of the PHN Programme cannot be sustained by the governmental health care system alone. A determined effort would, therefore, be made to involve and expand the role of communities, non-governmental organisations and the private sector. These would be focused in five key areas: the establishment of community co-financed and managed health care, as the lowest tier of the health system, utilising as a point of entry the Bamako Initiative approach; the possible sub-contracting of health care provision to non-governmental organisations, especially in remote or particularly vulnerable areas; a reduced role for the state in those service areas in which the private sector can be active such as urban, curative care; the progressive development of a health insurance system; and increased emphasis on traditional medicine.

(h) Expanded utilisation of services: The increased availability of relevant and better quality health care would need to be matched by a concomitant expansion in the demand for and utilisation of services. While improved care would, to a significant extent, be self-promoting, additional effort would need to be made to fully exploit the potential for increased use. This would be achieved through integrated and sustained IE&C programmes (the design and operation of which are described in the appropriate sections of the Advocacy Programme).

4. Programme Activities

4.1 Launching a District Capacity-Building Initiative (DCBI)

This activity would represent an expansion and intensification of the Strengthening of District Health Systems (SDHS) Initiative which is already being implemented. The preparation of the DCBI would be preceded by an evaluation of the impact of the SDHS Initiative, to be completed by the end of 1993.

Without pre-empting the recommendations of the evaluation, the DCBI may contain the following components: a review of the structure of district health management teams to assess its adequacy for decentralised operations; based in part on the latter, the preparation of a common policy and procedures manual for the governmental health system, incorporating the decentralisation of major operational functions to the districts (see also Activity 4.3); the consolidation and expansion of regular in-service and external (that is, outside the district) training programmes in health management (data collection and analysis, microplanning, programming, budgeting, human resource management) and other technical issues related to health care for district and sub-district level staff; the development of a programme of technical assistance to districts to facilitate the establishment and/or strengthening of monitoring, logistics and supply and payroll systems (see also Activity 4.5); and the articulation of a revised framework for community-based health care as an integral part of the district health system as well as the development of a programme of assistance to communities (see also Activity 4.7).

The formulation of the DCBI would be completed by the end of 1994. Implementation would commence in 1995 with the objective of covering 50 percent of all districts by the end of 1998. Pending the outcome of an evaluation in 1998, the Initiative would be extended to the remaining districts by 2002. It is hoped that the transfer of centralised functions would be phased in line with the implementation of the DCBI.

4.2 Increasing Physical Access to PHN Services

The two principal activities in this area would be the construction of additional facilities at the district and sub-district levels and a substantial expansion of outreach services from newly-established and existing fixed facilities. In both areas, the emphasis would be on the increased provision of integrated services with a focus on maternal and child health and family planning (MCH/FP).

According to recently available data (MOH, MCH/FP, 1990), there were a total of 1405 health institutions countrywide providing MCH/FP services in 1990 of which 584 were managed by the MOH. Thus, in addition to the Ministry's facilities, there were also 821 quasi- and non-governmental institutions providing such services. It should be noted, however, that not all of these 1405 health institutions were offering an integrated and comprehensive service package. In the long-term, a total of 429 new facilities would be required to meet the PHC guidelines (1978) of one health institution responsible for an area within a radius of 8 kilometres. Of this total, the MOH has calculated that 160 institutions, among which 34 would be district hospitals, could be constructed by the end of 1996. Taking into account existing activities, a phased programme of construction would be launched by 1993 to build the required 160 facilities by 1996. Depending on the availability of funding (see also Activity 4.6 below), the remaining shortfall would be covered by 2002. Activities would be targeted initially on the most poorly served areas of Ghana.

As a complement to the construction programme and to enhance efficiency, all 584 institutions currently delivering MCH/FP services would, by 1994, be supported to provide integrated and comprehensive MCH/FP services on a daily basis at every service delivery point (see Activity 4.3 below). Of this total, 334 Health Centres and Posts (Level B stations) would provide service at 12 outreach points in their catchment areas once a month, giving a total of about 4000 such points each month countrywide (the remaining 250 institutions, such as MCH/FP centres, are not equipped or designed to provide outreach services). With the commissioning of an additional 160 facilities by 1996, it would be possible to increase the number of outreach points by almost 38 percent to approximately 5500 points each month countrywide. Furthermore, the existing 821 private institutions not yet providing daily integrated and comprehensive MCH/FP services would be assisted to provide such services by the end of 1996. The support envisaged would include training of staff and at-cost provision of equipment and supplies.

4.3 Developing PHN Services

Increased institutional capacity as well as improved physical access would underpin the development and strengthening of integrated PHN services at the various levels of the health system. Thus, at the community/village level, the focus would be on the monitoring of health and nutritional status, the availability of essential drugs, service provision through trained community health workers (CHWs) and community-wide action on hygiene and environmental sanitation. This rudimentary health care system would be operationalised through a number of activities, some of which are already underway. These would include:

(a) the introduction and use of community registers to improve record-keeping on vital events and assist in tracking coverage of services such as immunisation;

(b) the establishment of a community-based growth monitoring system;

(c) the progressive extension of the Bamako Initiative strategy, using a revolving fund for essential drugs as a point of entry for improved community management of PHC (see also Activity 4.7 (a));

(d) the training and supervision of Community Health Workers/CHWs (such as TBAs) to ensure proper ante-natal, delivery, and post-natal care and increase access to family planning services (non-prescriptive);

(e) increased reliance on community-based distribution of modern contraceptives through TBAs, traditional healers, chemical sellers and market women ;

(f) continuation of community-based weaning foods projects; and
(g) encouragement of community action to tackle environmental sanitation problems such as poor surface drainage and the collection and disposal of refuse.

Community level care would be supplemented by monthly outreach services from Level B facilities (health centres/posts). An integrated array of MCH/FP services would be provided at the outreach point including growth monitoring, ORT, immunisation, health and nutrition education, treatment of ARI as well as minor ailments and family planning. These visits would also provide opportunities for Level B staff to examine community registers, assess local management of essential drugs, provide and update "road-to-health" charts, and train and supervise CHWs. In-between outreach services, mothers and children with serious health conditions would be referred by CHWs to the nearest health centre/post. Particular attention would, therefore, be given to the establishment of some form of communication link between levels A and B and appropriate modes of transportation for seriously ill persons, especially pregnant women suffering from complications.

Outreach would also be extended into a new area, that is, schools. Plans are already well advanced for implementing a national school health programme. A draft policy has been adopted and operational guidelines are expected to be developed by the end of 1992. The objective is to establish multi-disciplinary school health teams in all districts and extend coverage to half the schools in the country by 1994. The programme would encompass "....feeding, periodic health screening of pupils, delivery of routine health services and the teaching of environmental hygiene and health education in....schools," (People's Daily Graphic, March 4, 1992).

At the health centre/post, an array of one-stop services, similar to those at the outreach points, would be provided on a daily basis by a team of trained professionals. In addition to their responsibilities for data collection and analysis as well as the training and supervision of CHWs, Level B staff would also refer complex cases (including those needing surgical intervention) to Level C, that is, the district hospital. The latter would not only provide specialised assistance but also integrated MCH/FP services on a daily basis.

The types of services described above are being and could be provided through improved organisation and more efficient use of resources. Nevertheless, substantial expansion in the coverage and quality of such services, as recommended in this sectoral programme of action, would require additional investments. The MOH-HQ would, consequently, need to make an assessment of the long-term recurrent and capital costs of such a level of service provision (a start on which is represented by the attached budget for the PHN Programme). The other activities within this sectoral programme of action - especially 4.1, 4.2, 4.4. 4.5 (b)/(c) and 4.7 (a) - would represent a component of these costs. As for higher levels of funding to sustain expanded efforts, the options are discussed under Activity 4.6.

4.4 Dealing With Specific Health and Nutrition Problems

Strategies need to be strengthened to cope with specific health and nutrition problems. The suggestions discussed below build upon existing approaches with one important difference: they are not being proposed as the core of vertical programmes for individual problems but rather as operational elements within the decentralised and integrated services described in Activities 4.1 - 4.3 above. They are presented below, according to each major health and nutrition problem:

(a) Malaria: In order to substantially influence the incidence of malaria, anti-malarial therapy would be provided to effectively treat 80 percent of all febrile episodes in children under five years of age and pregnant women. This would be ensured through the use, at levels A and B, of manuals on appropriate treatment which are to be produced in 1992. Chloroquine prophylaxis would be made available at all ante-natal clinics (public and private) and the treatment received would be recorded on ante-natal cards.

Other control measures would include investigations of the potential impact of chemical-dipped mosquito nets, as a preliminary to large-scale use. Public education programmes would also continue on appropriate treatment, environmental hygiene and preventive measures such as the increased use of netting (see Activity 4.8). Last but not least, changes in the physical

environment would be made through sanitary means of excreta disposal, better refuse disposal and improved drainage around habitations (see the Water Supply and Sanitation Programme for details).

(b) Acute Respiratory Infection (ARI): Prompt diagnosis and effective treatment of ARI is the key to the reduction of complications and deaths. As part of training activities at the sub-district level and on-going education campaigns, all Medical Assistants, Public Health Nurses (PHNs) and Community Health Nurses (CHNs) at Level B stations would be trained in the management of ARI in children. The impact of improved skills would be enhanced through the distribution of manuals to Level B staff indicating treatment schedules for ARI. This is expected to take place in 1992. Appropriate antibiotics (both broad and narrow spectrum) would also be provided to Level B stations manned by trained staff. These activities would be supported by public education programmes.

(c) Immunisable diseases: In view of the substantial investment which has been made in the past, the focus will be on the availability of daily immunisation services at all delivery points including all hospitals. In addition, immunisation against tetanus would be offered at all ante-natal clinics and recorded on ante-natal cards. The possibility of introducing a life-long TT vaccination card would also be explored.

Furthermore, the yellow-fever vaccine, which is already part of the vaccination schedule, would be made more widely available while efforts would be made to include hepatitis B vaccine in the schedule.

Public health staff would be advised to discuss possible side-effects from vaccination with mothers to allay any fears and to encourage them to complete the full course with regard to themselves and their children. To ensure that the target group of children under one and women of child-bearing age are reached, a defaulter tracking system would be institutionalised and use of the EPI Monitor strengthened. Moreover, emphasis would be placed on the appropriate use of community registers during coverage assessments.

In order to make this level of service delivery possible, efforts would be directed towards ensuring the uninterrupted operation of the cold chain system. Regular in-service training of staff would also be undertaken. Furthermore, public education on immunisation would be sustained over the programme period.

(d) Diarrhoeal Diseases: Within the health system, the emphasis would be on proper case management using existing guidelines. This would be supported through the establishment of ORT corners at every service delivery point and the continuation of on-going staff training in the control of diarrhoeal diseases. In addition, local production and marketing of ORS would be sustained to assist in the appropriate treatment of diarrhoea. Finally, there would be continuing public education on ORS and ORT including the use of homemade solutions such as rice water.

(e) Acquired Immune Deficiency Syndrome (AIDS): AIDS is primarily a sexually transmitted disease (STD) and, as such, is preventable. The principal focus would,therefore, be on the intensification of on-going public education programmes targeting both rural and urban populations but, especially, adolescents. The number of communication channels would be expanded beyond the formal media to include peer groups, women's associations, TBAs, traditional leaders, public and private health clinics and schools (particularly JSS and SSS). An expansion in the number of outlets selling prophylactic devices would buttress the effectiveness of educational programmes.

Preventive counselling is a also major component of AIDS prevention. Counsellors, for example, health and social workers and the staff of NGOs would be trained at both the regional and district levels to offer this service to the public.

Within the health system itself, staff would continue to be trained to deal with AIDS as a potentially serious public health problem. Efforts would be made to integrate AIDS into the STD Programme, given that adequate prevention and treatment of STDs such as syphilis and gonorrhoea, targeted on "high frequency transmitters", may change the pattern of HIV epidemiology. District hospitals would be equipped with AIDS screening equipment and chemical reagents to ensure the safety of their blood banks. Furthermore, the concept of one needle-one syringe-one injection would be widely promoted at all service delivery points, whether public or private. Health workers themselves would be protected against contamination from AIDS through the provision of adequate supplies of gloves and other necessary materials.

With the number of AIDS cases expected to increase in the next few years, the existing health infrastructure would not be able to cope with the number of patients requiring care. A system whereby people who suffer from long-term illnesses would be cared for in the home environment would have to be developed. Collaboration with NGOs, who already have experience at the community level, would be fostered to provide home-based care for all AIDS patients.

Another important problem would be children who have lost one or both parents to AIDS. Ways and means must be sought, through a support programme, to care for these children to ensure that their needs are addressed and to avoid their marginalisation from community life.

With regard to other sexually transmitted diseases, emphasis would be placed on raising awareness through public education, integrating detection and treatment services within the framework of family planning clinics and improving staff skills through training.

(f) Dracunculiasis/guineaworm disease: This health problem would be tackled at root through increased access to safe water supply in rural areas, as proposed in the Water Supply and Sanitation (WS/S) component of the NPA. Other significant preventive measures would include intensified IE&C in endemic areas and the provision of filters and chemical agents to improve personal, household and communal protection against the disease. The performance of these initiatives would also be monitored through effective surveillance.

(g) Nutrition: Good infant and child nutrition would be achieved though a variety of related efforts. They would include the promotion of breastfeeding (on average for 18 months) through aggressive and targeted ante-natal educational programmes in all public and private clinics. TBAs would be utilised to reinforce the message at the community level. Steps would be taken to discourage or even eliminate the use of breastmilk substitutes in hospitals. The "baby show" programme would be institutionalised to encourage mothers to breastfeed and adopt good nutrition and proper infant and child care practices. Another measure would be the regular de-worming of schoolchildren, an activity which is already being planned.

The community-based weaning foods projects would continue to be promoted. Educational campaigns and training/demonstration programmes would, however, be intensified to ensure greater participation of women in the projects. The range of income-earning activities would also be expanded to generate additional resources to support project activities. In order to monitor impact, nutrition surveillance would remain an important activity in those communities with production sites. Beyond the weaning foods projects and on a much larger scale, growth monitoring would progressively become a standard or routine activity in an increasing number of communities across the country.

Finally, a manual is expected to be produced in 1992 on the operation of Nutrition Rehabilitation Centres (NRCs). Level B staff would be trained to use this manual and provided with an update on the functions of the existing NRCs.

(h) Micronutrient Deficiencies: Iodine Deficiency Disorders (IDD) have been identified as a problem, particularly in the northern parts of Ghana. The extent of the problem is already being investigated and some preliminary activities have been initiated. In addition, epidemiological and KAPB studies would be carried out in 1992 on IDD (as well as other micronutrient deficiencies). Measures which would be pursued to deal with IDD would include educational programmes, the administration of capsules based on clinical findings and the iodisation of salt (depending on the results of on-going investigations).

As regards iron deficiency anaemia, the approach would include appropriate malaria prophylaxis and treatment (as discussed above) and supplementation with iron and multi-vitamin tablets, especially at ante-natal clinics. Public education on proper nutrition would continue, targeted especially at those areas where food taboos deny pregnant women access to protein-rich diets.

Vitamin A deficiencies would be counteracted through educational programmes on appropriate diets which, among other things, encourage consumption of palm oil and fruits. A multi-sectoral effort would be launched, based on past experience, to broaden the mix of locally-grown food crops. In the short-term, supplementation would be available at public and private clinics in areas with proven endemicity.

(i) Safe Motherhood: Measures in this area would involve the intensification of family planning programmes, continuation of TBA training, training in life saving skills for midwives, prompt referral of high-risk pregnancies, infection control in maternity wards and availability of blood banks at district hospitals. The strategies discussed for malaria, immunisable diseases and micronutrient deficiencies would be supportive of safe motherhood activities.

The phenomenon of teenage pregnancy would be tackled through the launching of a National Adolescent Reproductive Health (ARH) Programme. Preliminary steps have already been taken in this direction under the auspices of a multi-sectoral taskforce comprising representatives from relevant governmental and non-governmental agencies. This taskforce has followed up its policy formulation sessions with the institutionalisation of quarterly monitoring meetings during which all agencies report on progress, constraints and action to be taken. An ARH report is also available for 1991.

The strategies being proposed by the taskforce can be distilled into four principal elements. Firstly, the target group (boys and girls between the ages of 10 and 20) as well as parents would be made more aware of the dangers of teenage pregnancy and possible preventive measures through mobilisation of all communication channels. This would embrace family life and parent education in schools/literacy programmes and the dissemination of information through formal and informal media such as radio, television, cinema, churches, mosques and women's associations. Peer counselling programmes would also be established to reinforce the message delivered through IE&C activities.

Secondly, all youth programmes related to ARH would be integrated or better coordinated. Thirdly, programmes would be made more sustainable, culturally sensitive and relevant. Finally, the impact of greater awareness on the issues as well as improved access to ARH Programmes would be buttressed by the increased availability of family planning services generally and contraceptives, in particular. In this regard, attention would be paid to the development of an age appropriate delivery system in terms of facilities, personnel and training.

4.5 Developing/Strengthening Support Services

To provide adequate back-up for the decentralised provision of health care, both the regional and national levels of the health system would need to be strengthened. There would be a focus on four essential areas:

(a) Policy Analysis, Planning and Budgeting: Given the paucity of useful data, a review would be launched of basic information requirements for health management at the different levels, to be completed by 1993. On the basis of this review, existing data sources, formats and collection procedures would be consolidated and rationalised into a comprehensive national health information system. The proposed modifications would be finalised by the end of 1994 with implementation commencing in 1995. The revised system would be fully operational by 1998.

In addition, the three principal planning functions at MOH-HQ - policy planning and analysis, information and research and external aid coordination - would be supported with adequate manpower by 1995. Similarly, both the district and regional health teams would be required to identify a focal member for planning, as an initial step in the strengthening of capabilities at those levels. If necessary, training would be provided to staff both locally and abroad (preferably through short-duration courses). Depending on the outcome of an assessment of computing capabilities and requirements, appropriate additional equipment and software would be provided at the different levels (minicomputers, microcomputers, portable computers, scanners, printers, word and data processing packages). Capacity-building at the district level is discussed more thoroughly under Activity 4.1.

The aim would be to have a core national planning team by 1997, if not earlier, and the rudiments of a comprehensive national health planning system by 1998. Full capabilities would be achieved by 2002. It is hoped that, as a result of these activities, it would be possible for the MOH-HQ to prepare policy papers on key issues, publish an annual health survey of the country as well as undertake multi-year, programme-based budgeting (for indicative purposes) by 1998.

(b) Human Resource Development and Management: Three essential activities would be pursued in this area. Firstly, an assessment would be made of the manpower requirements of a decentralised health system and the local capacity to satisfy the demand. Secondly, and related to the latter, a review would be launched on the content and orientation of health-related academic programmes with the aim of making the latter more relevant to the needs of the country, especially in terms of training personnel for the sub-district and community levels of the health system. As a follow-up to the study, proposals would be developed on necessary changes in institutions and programmes. Finally, guidelines would be revised and/or developed on staff recruitment, promotion and compensation within a decentralised system. A critical aim would be to identify possible incentive schemes to retain and motivate staff. All three tasks would be completed by the end of 1995.

(c) Logistics and Supply: To ensure uninterrupted service provision and reduce delays as well as waste, there would need to be a steady flow of drugs, equipment and supplies within the health system, an area in which the MOH-HQ has experience and expertise. The supplies management functions at headquarters would, therefore, be strengthened in the following areas: procurement (to be eventually relinquished to the Ghana Supply Commission), storage, distribution and inventory control. This would entail simplifying procurement procedures and expediting document processing, rehabilitating and/or expanding major storage facilities at all levels, and developing a computerised inventory control system at MOH-HQ. These activities would be completed by 1997.

Maintenance plans would also be drawn up for the health system to ensure that the best use is made of equipment and supplies. This would involve the development of in-house maintenance capabilities and/or the sub-contracting of tasks to the private sector. Parallel to improvements in supply and logistics, an effective maintenance system would be operational by 1997.

(d) Inter-sectoral coordination: Health care, especially PHC, is not the concern solely of health institutions but also others engaged in water and sanitation, agriculture, community development and local government. As a consequence, an institutional structure needs to be established at all levels of administration to achieve better inter-sectoral coordination and maximise benefits from available resources.

At the national level, the best technical forum for such coordination would be the proposed Health Advisory Board assisted by the MOH's Public Health Bureau or its equivalent. Macro planning issues, on the other hand, could be addressed in the Cross-Sectoral Planning Group for Human Development (CSPG-HD) within the National Development Planning Commission (NDPC). At the regional level, a forum for coordination would need to be developed, perhaps under the umbrella of a Social Sector Sub-Committee of the Regional Coordinating Council (see Chapter Six). This Committee could be assisted by the Regional Health Management Team (RHMT) and the Regional Planning and Coordinating Units (RPCUs) when they are established.

Finally, at the district level, the Social Sector Sub-Committee of the Assembly would provide the relevant arena for coordinating activities. The capacity-building of the decentralised departments proposed in the Programme of Action would greatly facilitate this task as would the progressive strengthening of District Planning and Budgeting Units (DPBUs). The gradual entrenchment of composite budgeting could also prove to be an effective inducement for inter-sectoral coordination.

4.6 Mobilising Resources for PHN Services

The implementation of the PHN Programme will require additional resources. At the same time, the gains made possible through greater investment in the quality and coverage of PHN services would need to be protected from arbitrary cuts imposed as part of austerity measures.

Both the considerations noted above, therefore, argue for a broadening of the financing base for PHN services. This would be achieved through four major activities:

(a) A restructuring and progressive extension of fees within the framework of the "cash-and-carry" system to ensure that at least 15 percent of recurrent costs are recovered from users, with 100 percent retention of funds by the level of the health system at which they are collected. The fee structure may involve an element of cross-subsidy through price differentiation between urban and rural areas as well as exemptions for the poorest. Given the lack of analysis on these issues and the administrative costs of identifying the poor, a menu of options would be investigated before being extended throughout the national territory, commencing in some or all of the five districts in the country currently involved in the Bamako Initiative (see Activity 4.7 below). The investigatory phase would be followed by the development and production of guidelines and procedure manuals for effective and uniform implementation. Success in this regard would also act as a catalyst for wider adoption of the Bamako Initiative strategy. Since the "cash-and-carry" system has already begun operations, the proposed activities would be completed by the end of 1994.

(b) An expansion of local level financing for basic services, that is, from districts and communities. In view of the responsibilities assigned to them and their relatively new, albeit limited, revenue raising authority as well as funding from the central government, districts would be required to fund an increasing share of capital and recurrent costs. This would be

coordinated with larger, catalytic investments by the central government. For example, staff accommodation for a centrally-funded health post would be financed by districts. District authorities would, therefore, be required to provide realistic projections of revenue availability and establish guidelines for resource allocation consistent with planned investments in the area. This approach would be targeted, in particular, at the more developed districts within the country, especially in the south. Activities could commence as early as 1993. With regard to community financing, the issue is discussed below as part of Activity 4.7.

(c) Adequate allocation of funds from the central government and increased efficiency of use. Allocations within public expenditure for PHN services are relatively low compared to spending on education and economic infrastructure. Under these circumstances, the government would need to assess likely resource availability over the programme period and examine the possibilities for increased allocations. This would incorporate the principle of reserving the dominant share of additional funding for PHC. Follow-up studies to this National Programme of Action would be commissioned to provide recommendations by mid-1993.

(d) Restructuring of donor assistance. The limited data available on this issue (UNDP, 1991b) suggest that only 13 percent of disbursements between 1984-90 were directed towards the social sectors generally. Discussions could, therefore, begin with donors to explore the possibilities for expanded funding through aid restructuring and/or provision of additional resources, especially in view of the Donor Conference for the African Child scheduled for November 1992. This activity could commence in the last quarter of 1992 and be incorporated into the preparations for the next meeting of the Consultative Group for Ghana.

In addition to the activities above, guidelines would be developed for protecting essential expenditures during austerity. A broadening of the financing base would contribute to achieving this objective but additional analysis would have to be undertaken to identify those specific elements of public expenditure which would need to be protected during stabilisation. The follow-up studies mentioned in 4.6 (c) would address this issue and provide recommendations by mid-1993.

4.7 Achieving Sustainability

The PHN Programme is too large to be sustained solely through the efforts of central and local governments. Under these circumstances, activities would be launched in several areas to more evenly spread responsibility for the Programme and, at the same time, engender a greater sense of participation and ownership among relevant groups. The activity areas would be as follows:

(a) Expansion of community-based health care. As a first step, the results of the review of the Bamako Initiative carried out in 1992 would be utilised to formulate a national framework clarifying, in particular, the relationship between communities and the governmental health system, in the areas of financing, management and technical assistance and supervision. This policy framework would also set targets for the extension of community-based health care and identify strategies for achieving these targets including the Bamako Initiative. The national framework would be finalised by the end of 1993.

Without preempting the content of the framework, it would probably be necessary to develop a consolidated programme of assistance to communities. Such an initiative could, for instance, provide training courses in basic health care and management for Community Health Workers (CHWs) and Management Committees, respectively; assistance with the use of simple monitoring tools; logistical support for improved communication and referral; and a jointly agreed format for technical supervision from Levels B and C. It could begin to be implemented by 1994.

(b) Sub-contracting of service provision to NGOs. The organisational structures, operational mode and lower costs of NGOs are well suited to the challenge of reaching well-defined areas and target groups which are located in remote areas or are particularly vulnerable. Service provision could, therefore, be sub-contracted to NGOs in these specific circumstances. This would constitute a new approach in Ghana and would necessitate an initial period of testing. Thus, discussions which have already begun with NGOs on this issue would be continued during 1993, both to assess their ability and willingness to participate in this initiative. Contingent upon a favourable outcome to these discussions, a few test cases could be implemented in the first quarter of 1994 for evaluation in 1996.

(c) Greater participation of the private sector in health care. A key activity would be to assess the capacity of this sector to provide comprehensive care in urban areas. A study on this issue would be launched in 1993 with recommendations finalised by the first quarter of 1994. If this approach is found to be feasible, then it would be possible for the MOH to restrict large, additional investments in urban, curative care and reallocate funds, among other things, to urban PHC programmes in deprived areas. This would represent a more efficient and equitable use of limited public resources.

(d) Development of a national health insurance system. With the completion of a pre-feasibility study, a follow-up feasibility study is currently underway with a report expected to be submitted to the Government in 1992. Depending on the recommendations made in the report as well as a final decision by the Government, an insurance system would be tried, on an experimental basis, in districts with relatively developed health management capabilities, which may include those currently implementing the Bamako Initiative. Preliminary activities could start in late-1993.

(e) Increased emphasis on the use of traditional medicine. This would require an acceleration of the on-going reorganisation of the practice of traditional medicine, particularly with regard to the compilation of a National Register (by region); the identification of different areas of specialisation, for example, the treatment of infertility and infant paralysis; validation, testing of preparations and certification in collaboration with the Ghana Standards Board and the Centre for Plant Medicine and Scientific Research; and training and documentation.

4.8 Increasing Utilisation of PHN Services

To substantially increase the utilisation of services, IE&C programmes would be expanded and intensified to raise awareness on appropriate health, nutritional and family planning practices as well as "market" MCH/FP services. Within the framework of the national coordinating mechanism proposed in the Advocacy Programme, the MOH, in collaboration with other relevant ministries/organisations such as the Ministry of Local Government and the Ghana Water and Sewerage Corporation (GWSC), would design, produce and disseminate appropriate MCH/FP communication materials for the target groups. The Ghana Broadcasting Corporation (GBC), in collaboration with the National Film and Television Institute (NAFTI), would also develop specific programmes, including dramas, on relevant topics for broadcast on radio and television. Facilities of the Information Services Department (for example, cinema vans) would be used to support IE&C activities.

Furthermore, the Ghana Social Marketing Programme (GSMP) could be given an expanded role in promoting integrated and comprehensive MCH/FP services, beyond its current focus on family planning and ORT. Finally, the MOH's Programme of Multi-Media Approach in Family Health Communication, currently being implemented in Brong Ahafo, Ashanti and Central Regions, would be extended to the other seven Regions by 1996.

In view of the extensive nature of the activities described in this Programme, it would be necessary to identify the priorities, based on the following criteria: responsiveness to identified pressing needs; consistency with on-going or planned interventions; sustainability; ease of implementation; and cost-effectiveness. Using the latter, the cluster of priority activities would include 4.1, 4.2, 4.3, 4.4, 4.5 (b), 4.6 (a) and (c), and 4.7 (a).

5. Programme Monitoring

A key set of indicators for the overall implementation of the PHN Programme would be the activity deadlines suggested above. Additional indicators for operational purposes would include measures of input flow (such as resource allocation and use, numbers of personnel/health workers trained, purchases of equipment and supplies) and outputs, for example, the numbers of people reached with integrated PHN services. The data would be generated from existing and revised reporting forms and internal records at the different levels of the health system. They would include information collected at the community level. Evaluations of impact, such as reductions in morbidity and mortality, would be assessed through the use of sentinel sites and periodic surveys. It is proposed that a comprehensive survey on social indicators be launched on a national scale every five years, based on a modification of the Ghana Living Standards Survey (GLSS) and/or the Ghana Demographic and Health Survey (GDHS).

In the monitoring system being suggested, information on MCH/FP services in the catchment area of each health centre/post would be compiled and analyzed monthly at both the health centre/post and district headquarters by focal persons trained in health planning/information systems. Based on the analysis, immediate remedial action would be taken at the sub-district and district levels. The district headquarters would, in addition, compile and submit a consolidated monthly report to its regional headquarters. At the regional level, a similar analysis would be conducted on district level performance. Remedial action would be taken through immediate feedback to districts. Reports on regional performance would also be compiled and sent to the MOH-HQ every quarter.

In order to appraise performance and update strategies, meetings would be held at all levels every six months, to review quarterly performance. At the sub-district level, the Medical Assistant and his/her team and the Institutional Management Committee would review catchment area and institutional performance and take corrective measures. Areas of performance review at this level would include monitoring of: inputs such as drug utilization in relation to disease patterns, fee returns, performance of cold chain equipment and level of supervision and performance of TBAs and CCAs; outputs, for example, coverage assessment of the target groups and service utilization including use of the road-to-health charts at Outpatient Departments (OPDs), immunisation performance, effectiveness of ORT-Corners and the level of community participation; and, last but not least, "impact" assessment as shown by the reported incidence of immunisable and communicable diseases.

At the district level, the District Health Management Team (DHMT) would conduct the review with relevant staff from the sub-district level (health centres/posts) and other private or NGO-funded health institutions. Areas of performance review at this level would include, in addition to those mentioned above: inputs such as the efficacy of health information systems, management of services, effectiveness of training and in-service training programmes and the level of integration of health services; outputs such as district-wide coverage of target groups; and "impact" as indicated by changes in the district's epidemiological profile.

At the regional level, Regional Directors of Health Services (RDHS) with their Regional Health Management Teams (RHMTs) would conduct the review with the DHMTs and other members of the health team, both private and NGO. Areas of performance review at this level would include: inputs, for instance, district capabilities in the management of integrated health programmes and health information systems, training and in-service training programmes, the extent of financial autonomy of districts and effective utilization of the district's budget for integrated health services; outputs such as the region-wide coverage of services and level of service utilization; and "impact" in terms of the regional epidemiological profile. In addition, regular assessment of performance through surveys would also be undertaken. In the case of immunisable diseases,

coverage assessment using WHO cluster sampling survey methods would be carried out every triennium to complement the results of the MOH's internal reporting system. As a further check, survey results would be matched with disease surveillance reports which would be compiled in at least three sentinel sites to be established in each region.

Similarly, at the national level, some members of the RHMTs from the ten Regions would review performance with the Director of Medical Services and his team and develop corrective measures. As elsewhere, the private sector and NGOs would also be involved. The review meeting on regional performance would, in fact, become part of the annual RDHS conference. The reviews would focus on effectiveness and efficiency in the management of integrated health services in the context of a comprehensive National Primary Health Care Programme. At all levels, these review meetings would serve to reinforce and upgrade the skills and knowledge of health workers in preventive health measures.

6. Programme Management

The overall management of the PHN Programme would be primarily the responsibility of the MOH-HQ, in particular, the offices of the Director of Medical Services and the Deputy Director for Public Health. The relevant divisions at headquarters would also be responsible for the development of policies and programmes and, to a lesser extent, implementation. Activities at the field level would be undertaken primarily by the relevant health authority, especially with regard to activities 4.3, 4.4, 4.6 (a) and (b), 4.7 (a) and 4.8. Finally, monitoring tasks would be carried out as indicated in section five above.

7. Programme Budget

The budget for the first five years (1993-97) is shown in the summary table below.

NATIONAL PROGRAMME OF ACTION ON THE FOLLOW-UP TO THE WORLD SUMMIT FOR CHILDREN
CAPITAL AND RECURRENT COSTS FOR 1993-1997
(IN USD 000' AT 1992 PRICES)

COMPONENT: POPULATION, HEALTH AND NUTRITION (PHN) PROGRAMME
SUB-COMPONENT: S U M M A R Y

CAPITAL COSTS

INPUT	UNIT	PHYSICAL QUANTITIES						UNIT COST	CAPITAL COSTS					TOTAL	% OF TOT
A. CIVIL WORKS		PY1	PY2	PY3	PY4	PY5	TOTAL		PY1	PY2	PY3	PY4	PY5		
1. District Hospital	no.	-	10	10	14	-	34	2500	-	25000	25000	35000	-	85000	
2. Level 'B' (Health Centre)	no.	6	30	30	20	40	126	900	5400	27000	27000	18000	36000	113400	
3.	no.														
Sub-Total									5400	52000	52000	53000	36000	198400	
B. EQUIPMENT/ FURNITURE															
1. District Hospital	no.	-	10	10	14	-	34	250	-	2500	2500	3500	-	8500	
2. Level 'B' (Health Centre)	no.	6	30	30	20	40	126	100	600	3000	3000	2000	4000	12600	
3. Aids Screening	no.	55	55	-	-	-	110	10	550	550	-	-	-	1100	
4. Others----------	no.														
Sub-Total									1150	6050	5500	5500	4000	22200	
C. SUPPLIES FOR															
1. District Hospital	no.	-	10	10	14	-	34	0.5	-	5	5	7	-	17	
2. Level 'B' (Health Centres)	no.	6	30	30	20	40	126	0.1	0.6	3	3	2	4	13	
3.	no.														
Sub-Total									0.6	8	8	9	4	30	

INPUT	UNIT	PHYSICAL			QUANTITIES			UNIT COST	CAPITAL		COSTS			TOTAL	% OF TOT
D. TECHNICAL ASSISTANCE		PY1	PY2	PY3	PY4	PY5	TOTAL		PY1	PY2	PY3	PY4	PY5		
1. Long															
a) External	p/m														
b) Local	p/m														
2. Short															
a) External	p/m	6	4	4	4	4	22	6	36	24	24	24	24	132	
b) Local	p/m	5	2	2	2	2	13	3	15	6	6	6	6	39	
Sub-Total									51	30	30	30	30	171	
E. TRAINING/ ATTACHMENTS															
1. Workshops/Seminars	p/m	6724	3090	1889	3299	2230	17232	0.1	672	309	189	330	223	1723	
2. Long Term	p/m	1	-	-	-	-	1	4	4	-	-	-	-	4	
3. Attachments	p/m	-	-	-	-	-	-	-	-	-	-	-	-	-	
4. Manuals/Materials	no.	8056	24870	2270	22930	1910	60036	0.01	80	249	23	229	19	600	
Sub-Total									756	558	212	559	242	2327	
F. VEHICLES															
1. Four Wheel Drive	no.	-	10	11	-	-	21	20	-	200	220	-	-	420	
2. Ambulances	no.	-	-	10	10	14	34	35	-	-	350	350	490	1190	
3. Motor-Cycles	no.	-	10	10	10	14	44	1.5	-	15	15	15	21	66	
Sub-Total										215	585	365	511	1676	
G. OTHERS															
1. Supp. for C'ty Initia.	no.	-	-	-	-	-	-	-	-	220	220	220	220	880	
2. C'ty Registers	no.	-	20000	10000	-	-	30000	0.005	-	100	50	-	-	150	
3. I E & C.	no.	-	-	-	-	-	-	-	-	100	100	100	100	400	
4. C'ty Drug Storage	no.	-	-	-	-	-	-	-	-	-	-	100	50	150	
5. Malaria - Pilot Proj.	no.	-	-	-	-	-	-	-	50	50	50	50	50	250	
6. EPI/Diarrhoea	no.	-	-	-	-	-	-	-	956	287	278	277	282	2080	
7. Nutrition	no.	50	50	50	50	50	250	10	500	500	500	500	500	2500	
8. Micro-Nutrients	no.	-	-	-	-	-	-	-	60	-	-	-	-	60	
9. Safe Motherhood	no.	4	3	-	-	-	7	252	1008	756	-	-	-	1764	
Sub-Total									2574	2013	1198	1247	1202	8234	
GRAND TOTAL CAPITAL									9932	60874	59533	60710	41989	233038	

RECURRENT COSTS

INPUT	UNIT	PHYSICAL QUANTITIES						UNIT COST	RECURRENT COSTS					TOTAL	% OF TOT
		PY1	PY2	PY3	PY4	PY5	TOTAL		PY1	PY2	PY3	PY4	PY5		
1. Personal Emoluments															
a. Existing	p/m	14	106	107	111	51	389	0.2	2.8	21.2	21.4	22.2	10.2	78	
b. District Hospitals	no.	-	-	500	1000	1700	3200	1.1	-	-	550	1100	1870	3520	
c. Health Centres	no.	-	90	540	990	1290	2910	0.9	-	81	486	891	1161	2619	
2. Vechicle Operating Cost		-	-	-	-	-	-	-	-	21	58	36	51	166	
3. Other Operating Cost															
a. District Hospitals		-	-	-	-	-	-	-	-	-	165	330	561	1056	
b. Health Centres		-	-	-	-	-	-	-	-	24	146	267	348	785	
TOTAL RECURRENT									2.8	147.2	1426.4	2646.2	4001.2	8224	

EDUCATION PROGRAMME

1. Background

1.1 The Problem

Like all other sectors, education suffered severely from the protracted period of decline experienced by Ghana between the early seventies and eighties. To take a few cases in point, real expenditure per capita (1975 prices) declined by more than 70 percent between 1975-82, capital investments were negligible, the proportion of trained teachers in primary schools dropped from 71 percent in 1976-77 to 54 percent in 1980-81 and there was a chronic shortage of essential supplies and equipment (UNICEF-Ghana, 1984, 1986).

As a comprehensive response to this difficult situation, the GOG launched an educational reform programme in 1987, to significantly improve the quality and coverage of basic education (see section 2.2 for details). While the integrated package of educational reforms have focused on basic education, secondary and tertiary levels have also benefited. Among the achievements of this programme have been the reduction of pre-university education from 17 to 12 years, the lengthening of the academic year from 33 to 40 weeks, improved relevance of the curricula for basic and secondary education, expanded and strengthened teacher training and a greater emphasis on sustainable financing. As a consequence, the programme has succeeded in accelerating the rate of increase in enrolments in basic education. For example, enrolments in the first grade of primary school grew by almost 12 percent between 1988-89 and 1989-90 (World Bank, 1990b). Reflecting this improvement, the most recent data from the MOE (1992) show that the gross enrolment ratio in primary schools (grades 1-6) was an encouraging 82.5 percent in 1990.

Despite the progress being made through the reforms, significant problems still remain to be tackled in the sector. Among the principal challenges is the high level of child and adult illiteracy. According to the GLSS (1989), 89 percent of children aged 9-14 years are illiterate. Among individuals aged 9 years and older, 58 percent and 77 percent of males and females, respectively, are illiterate. This poor performance is explained, in part, by low net enrolment ratios and poor retention in schools. Thus, in counterpoint to the gains in the gross enrolment ratio mentioned above, estimates from an albeit earlier source (GLSS,1989) show that the net enrolment ratio (that is, among the relevant age group, 6-11 years) was a less impressive 67 percent in 1987/88. Making matters more problematic, recent data suggest that the rate of "wastage" could be as high as 40 percent in primary schools (MOE, PBME, 1988/89). Earlier studies (Pandit et. al., 1989) had estimated this rate to be about 27 and 36 percent for boys and girls, respectively. Higher "wastage" suggests that the primary school completion rate may be as low as 60 percent.

Participation in the formal education system also varies considerably according to geographic location, gender and economic status. For instance, the gross enrolment rates in the three northern regions of the country (Northern, Upper West and Upper East) is less than 50 percent. Similarly, pre-school enrolment is concentrated in urban centres, mostly in the south. These outcomes reflect disparities in access to facilities and trained manpower. For example, even though it has roughly the same population as Brong Ahafo, the Northern Region has about a third fewer primary schools (GOG/UNICEF, 1990). The proportion of trained primary school teachers ranges from 87.4 percent in Greater Accra Region to 44 percent in the Northern Region (ibid).

There are also gender disparities in access to and retention within the education system. Although gross enrolment rates for boys and girls nationally do not vary substantially for primary education, there is a marked gender gap in the northern part of Ghana where girls represent only about 33-40 percent of total enrolment (MOE, 1988). Across the country, decreasing proportions of females are enroled at progressively higher levels of education such as senior secondary schools in which they constitute only a third of total enrolment (MOE, 1990). In addition, as was shown above, even in the case of primary education, the dropout rate for girls is significantly higher than for boys.

The rising cost of education represents another source of concern. Although basic education is free and compulsory in Ghana, the payment of textbook user fees and the need to buy school supplies could be placing formal education outside the means of a large number of Ghanaian families. Moreover, since many poor families require their children for farming or other income generating activities, they are often forced to

choose between educating their children and supporting the family. This already difficult situation was aggravated in the early 1980s by the economic crisis which pushed many families even closer to the margin of survival. Although per capita GDP has increased reasonably in the last seven years, the distribution of the benefits of that growth has been uneven and poverty still remains widespread. This continues to limit educational opportunities for many.

As costs increase, the issue of the quality of education being paid for becomes more pertinent. There is still substantial room for improvement in this area in terms of the physical environment of instruction, the qualifications of instructors and the availability of basic materials and equipment. In the case of primary education, schools in many parts of the country are dilapidated, a large proportion of teachers (about 44 percent) have had no preparation for their profession while the ratio of pupils to textbook is still not satisfactory.

As with almost all indicators, conditions are worse in pre-schools, especially those located in rural areas. A survey (GNCC, 1984) found that many facilities in these areas constituted a hazard to children because of the danger of collapse, most of the staff were untrained for their work and playthings were generally unavailable. Anecdotal evidence suggests that conditions are only marginally better in urban areas.

Recent data from the MOE show that more than 80 percent of teachers in pre-schools are untrained. This dismal situation reflects the current uncoordinated organisation of pre-school education. At present, the MOE provides only salaries for pre-school teachers and attendants, but no resource or child learning materials. To make matters worse, the conceptualization and quality of pre-school education has received little attention since the 1970s and, therefore, does not adequately prepare children for primary school, especially in a manner consistent with the on-going reform of basic education.

The limited retention of pupils and poor quality of education is reflected in low levels of achievement among children. As mentioned earlier, this is shown by the extremely high rates of illiteracy (almost 90 percent) among 9-14 year olds, most of whom have had between 3 and 8 years of schooling. Another study (World Bank, 1989b) reported that "....in many of the more remote areas, especially in the northern half of the country, the large majority (often more than 80%) of children completing grade 6 or even JSS 1, were completely illiterate."

The possibilities of remedying these problems depend, to a significant extent, on linking education with opportunities in the labour market. The challenge has already been taken up through the education sector reforms but intensified efforts continue to be necessary. The World Bank (1989b) has estimated that the "....total number of jobs in (formal sector) activities that basic school leavers may aspire to is only twice as high as the annual number of school leavers," (brackets added) so that most graduates would have little choice but to find work in the informal sector and farming. The establishment of closer links between schooling and employment will be critically important in influencing perceptions among both parents and children about the usefulness of school attendance.

1.2 Government Policies and Structures

The government's policy on basic education is embodied in the education reform programme. The specific objectives of this programme are to increase school enrolment faster than the rate of population growth, improve the content and relevance of the curriculum, attain a higher quality of education and ensure financial sustainability.

In pursuit of these objectives, the MOE has implemented a large number of measures including:

(a) a revision of the basic education curricula as well as the curricula of teacher training colleges;
(b) provision of in-service training to all heads of schools and to primary and junior secondary school teachers on the revised curricula and on continuous assessment techniques;
(c) preparation of innovative teacher training programmes designed to equip and upgrade untrained teachers with the knowledge and skills required by the new content of basic education;

(d) increased availability of instructional materials and textbooks in primary and junior secondary schools and improved sustainability of this measure through the institution of textbook user fees for cost recovery and replenishment of the textbook fund;

(e) development of consultative systems that promote greater involvement on the part of regional and district political authorities and communities to ensure their full participation in the implementation and co-ordination of educational reforms;

(f) improved coverage of the formal school system through support given for the construction and renovation of junior secondary schools;

(h) strengthened monitoring systems with particular attention being given to equitable access to education;

(i) revitalisation of non-formal education programmes to reduce illiteracy; and

(j) increased financial allocations to the education sector, particularly basic education (primary and junior secondary schools), with 3.5 percent of GDP being allocated to the education sector in 1989 compared to 1.7 percent in 1985.

With regard to governmental structures, the "....the Ministry of Education (MOE) is charged with the organization, supervision and coordination of the educational system. Overall responsibility is exercised by the Secretary for Education. He is assisted by three deputy secretaries in charge of School Education, Higher Education and General Administration as well as a Coordinator responsible for Non-Formal Education.

The School Education Division of the MOE works through the Ghana Education Service (GES) but also utilizes the Ministry's Planning and Inspectorate Divisions to work with teachers and heads of schools and colleges to ensure the smooth functioning of the educational system," (GOG/UNICEF, 1990).

The Ghana Education Service (GES) is itself structured into 6 Divisions "....each of which is headed by a Director of Education who is supervised, in turn, by the Director-General and his deputies who are responsible for the day-to-day functioning of the GES. In the case of primary and junior secondary schools, coordination and implementation is carried out by the Basic Education Division of the GES...." (ibid). The latter function is performed through directors of education at the district level. There is also a Pre-School Unit within the GES which is responsible for the pre-school curriculum and teacher training.

The MOE is also supposed to coordinate the activities of private primary schools which it does through the formulation of guidelines and policies. As part of the education reforms, private schools will have to follow the primary school syllabus in order to ensure that their pupils are prepared to enter the public JSS.

1.3 Non-Governmental and Donor Involvement

Non-governmental organisations and the private sector are actively involved in pre-school education. They are also involved in basic, particularly primary, education although enrolments in schools funded and/or managed by them are dwarfed by those in governmental institutions. Thus, enrolment in private primary schools as a proportion of total enrolment was only 7.3 percent in 1990 (MOE, 1992). Some of the important NGOs in the sector include the Churches, World Vision International, the 31st December Women's Movement and ORT. Church groups are also involved in functional literacy programmes as are GILLBT, Canadian Organisation for Development Education (CODE), Canadian Universities Service Overseas (CUSO) and the Jehovah's Witness Watchtower organisation.

There has been and continues to be a high level of donor support in the sector especially for pre-university education and functional literacy. Some of the major multilateral donors (post-1986/87) include UNDP (US$ 1.5 million for education planning), UNFPA (US$ 0.7 million for population/family life education), UNICEF (US$ 3.4 million for early childhood development, primary education and functional literacy) and the World Bank (US$ 120 million for the reform programme and tertiary education). Bilateral contributors are represented by Canada (functional literacy), Norway (US$ 2.9 million for functional literacy), Switzerland (C160 million for functional literacy), United Kingdom (3.6 million pounds for functional literacy and teacher education and 2.0 million pounds annually for scholarships targeted at health and education personnel) and the United States (US$ 35 million for primary education).

2. Programme Objectives

2.1 Principal Objectives

The principal objectives of the Education Programme are to:

(a) Increase the enrolment rate in pre-schools from about 10 percent to 30 percent;

(b) Increase the net enrolment rate in primary schools from 67 percent to 98 percent; and

(c) Increase the number of adult females (15 years of age and above) enroled in non-formal education programmes by 27 percent from 180,000 per annum to 230,000 per annum.

Supporting objectives are to:

(a) Eliminate gender disparities in primary education; and

(b) Reduce the rate of "wastage" from 40 percent to 20 percent.

2.2 Geographic Coverage and Target Populations

The Education Programme is expected to be national in scope. Nevertheless, activities would be particularly intensive in the three northern regions which are currently significantly below the national average on various measures of educational performance.

The target population for pre-school education will be children between 0-5 years of age or 3.3 million children, using the estimated population in 1990. In the case of primary education, the target groups will be children in the 6-11 year age group or 2.8 million children. Given gender disparities, however, special attention will be given towards reducing the proportion of girls in the relevant age group (46 percent) currently not enroled in primary schools or 0.8 million girls. Finally, the target group for non-formal education programmes will be females 15 years of age and above or 4.2 million women.

3. Programme Strategies

A linked set of strategies would be pursued to achieve the objectives of the Education Programme, consistent with and complementary to the reform programme. They would include:

(a) Increased emphasis on pre-school education: This is an area which has been overlooked in the education reforms. There are, however, important reasons for closing this gap: evidence from around the world suggests that children who have had pre-school education perform considerably better in primary schools, an important consideration, for reasons of efficiency and equity, in countries such as Ghana in which primary education is the only type of formal schooling received by most children; those in the relevant age group are among the most vulnerable children in the country, in terms of lack of proper supervision and care and exposure to environmental hazards; related to the latter problem, pre-school services provide an opportunity for reducing the burden of work on mothers and female siblings; and, finally, pre-schools offer the possibility of creating an institutional focus for providing child care services at the community level.

A multi-pronged approach would be launched to meet the challenge, taking into account both on-going and planned interventions. It would include a clarification of policy on pre-school education, development of appropriate institutional support, improved teacher training and the definition and active promotion of an operational framework for community-based and co-managed pre-school education. The latter consideration is particularly important in view of resource constraints on governmental activities.

(b) Expanded physical access to primary schools: It is evident that the availability and quality of physical infrastructure is an important constraint to greater participation in primary education, especially in poorer and remote areas. At the same time, it is also apparent that communities cannot be solely responsible for the construction/rehabilitation of primary schools, especially given the investments that they may have already made in JSSs.

Effort would, therefore, be directed towards increasing physical access in disadvantaged communities through joint financing schemes involving communities, NGOs and the government. The main thrust would be on providing assistance which could serve as a catalyst for community action. At the same time, access to schools would be rationalised to avoid duplication of facilities and, thus, the imposition of an unsustainable burden of recurrent costs on both communities and the government.

(c) Continued improvements in the quality of basic education: The success of the reformed structure and content of education will depend, in large measure, on improving the quality of services. This will influence the perceived attractiveness of school attendance as well as the learning achievement of students.

The construction/rehabilitation of primary schools discussed above would help in this regard. Additional steps would be needed, however, in two critical areas: the availability of equipment and textbooks and the quality of instruction. The aim would be to lower the ratio of pupils to textbooks through increased production and more efficient distribution. A related approach would be to fully equip JSS workshops, particularly in the most disadvantaged areas, through a collaborative arrangement between communities, government, the private sector and NGOs. With regard to the quality of instruction, the emphasis would be on improved and sustained pre- and in-service training to ensure that teachers have the necessary skills to provide instruction as required by the reformed curriculum. These would be supplemented through better supervision and assessment of teacher performance and improvements in conditions of service (see also (f) below).

(d) Strengthened links between schooling and employment: Neither children nor their parents can be convinced to reassess the opportunity costs of formal education without stronger links between schooling and entry into the job market. This point is particularly relevant for the graduates of JSS. An essential task would be to ease the transition of graduates from JSS to employment through appropriate "bridging" programmes. The main response would be to substantially expand apprenticeship programmes and restructure vocational training at the GES-run technical and vocational training institutes (see World Bank, 1989b). These changes would be supplemented by the testing of feasible financial and technical assistance schemes designed to enable trained school leavers to establish themselves in farming or the informal sector.

(e) Focused efforts for disadvantaged groups: There are a number of disadvantaged groups in the country which may not be able to improve their educational status solely through on-going changes in the education sector, due to in-grained gender biases, economic barriers or religious beliefs.

An attempt would be made through targeted and initially experimental projects, to reach these groups in ways which address the constraints to higher educational participation and performance. Among the priority groups would be girls, especially in areas where they are particularly under-represented in the formal system. Successful approaches which have been pioneered in other parts of the developing world, such as the BRAC model, would be adapted and tested in Ghana. On the other hand, women (that is, those 15 years of age and above) would be assisted to become functionally literate through an expansion of enrolments in the Non-Formal Education Programme which is already on-going in the country.

Another target group would be those who attend Islamic schools in the northern regions. Programmes would be designed in collaboration with Muslim religious leaders (national as well as loçal) to integrate elements of secular education into Islamic schools, especially the acquisition of minimum literacy and numeracy skills in the local and english languages. In these same areas, complementary efforts would be made to integrate shepherd schools with the formal educational system.

(f) Improved management of education services: Sustained improvements in the educational system will require better management of programmes at the major administrative level closest to the schools themselves, that is, the districts. At the same time, increased attention will need to be paid to the needs of human resource management to attract and retain qualified personnel and improve performance.

The most important task in the area of overall management would be to ensure that the District Education Offices are fully operational. This would be essential in view of the key role of the decentralised Offices in school supervision and monitoring. The proper execution of these functions is urgently required to improve school performance through increased accountability and technical assistance.

With reference to human resource management, greater attention would be paid to the conditions of service of teachers, to raise morale and provide incentives for better performance. Such an approach would complement the training aspect of human resource management discussed in (c) above.

4. Programme Activities

4.1 Increasing the Emphasis on Pre-School Education

A prerequisite for intensified efforts is the clarification of government policy on pre-school education. A policy proposal to this effect, embracing the broader concerns of early childhood education (for the 0-5 year age group), has already been submitted to the government by the National Advisory Committee on Early Childhood Education (NAC-ECD) chaired by the Ghana National Commission on Children (GNCC). Among other things, the proposal defines the purpose, structure and content of pre-school education and recommends an appropriate division of responsibilities among relevant institutions such as the MOE, the MMSW/DSW and GNCC. A major initial activity would, thus, be to secure a governmental decision on the proposal by mid-1993.

To support implementation of the new policy, an operational framework would be elaborated to promote increased community-based pre-school education. This would specify in detail the modalities for the provision of such services including the respective responsibilities of communities, district authorities, NGOs and the MOE. The issues to be addressed would include the siting of pre-schools, community level management, the training and supervision of personnel, the provision of necessary supplies and overall monitoring of programmes in the "sector". Upon approval of the policy proposal, the NAC-ECD would elaborate the operational framework by the end of 1993 for implementation in 1994.

Successful promotion of pre-school education would depend on the availability of adequate technical support from the MOE. Without pre-empting the government's decision on the matter, it appears that the Pre-School Unit within the GES would be best placed to provide such assistance. The Unit is, however, not equipped at present to meet expanded responsibilities. A set of activities would be pursued to strengthen the institutional capacity of the Unit. It would entail a higher level of staffing (including the posting of at least one Pre-School Officer in every district); orientation and training of personnel; the development of modalities for increased collaboration with other divisions of the GES (such as Basic Education, Curriculum Research and Development) as well as the MMSW and GNCC; and the provision of essential logistical support (such as office equipment). A short-term action plan containing the details of this exercise would be drawn up by the MOE/

GES concurrently with the operational framework. Implementation would commence in 1994 and would be completed by 1996, especially in the case of activities designed to raise the capacity of the Pre-School Unit at headquarters.

The final element would be to revise and expand training programmes for pre-school teachers and attendants. This would be undertaken within the framework of the existing Teacher Education Programme for first and second cycle schools. Activities would include a review and, if necessary, revision of the teacher/attendant training curriculum as well as the preparation and production of related training materials. These actions would be complemented through the development of pre- and in-service training programmes for pre-school teachers. There would be three principal foci: the upgrading of the existing Nursery Teacher Training Centre into a diploma awarding college for pre-school teachers; the development of short-duration pre- and in-service training courses for pre-school teachers which would be provided during school vacations, based at secondary schools and the Teacher Training Colleges (TTCs); and the provision of training courses for attendants at the community level using pre-school teachers as instructors.

The curriculum review/revision would commence in mid-1993 and be completed by the end of the year. The training programme for pre-school teachers would be finalised by mid-1994 with the production of relevant training materials completed by the end of the year. Implementation of the expanded training programme would begin in early 1995. The upgrading of the Nursery Teacher Training Centre would be completed between 1994-96.

4.2 Increasing Physical Access to Primary Schools

The principal activity would be the development and implementation of a financing scheme for the rehabilitation and construction of primary schools. This scheme would be modelled on the Community Initiative Projects (CIPs) within PAMSCAD. The objective would be to be provide grants from the central government to those communities willing to mobilise additional resources to carry out the necessary activities. The grant from the centre would also be complemented by assistance from district authorities. Given past experience, it is expected that this approach would be a cost-effective way of stimulating community action. In view of resource constraints, however, such a scheme would be phased, starting with a focus on the most disadvantaged areas. Emphasis would also be placed on optimising the use of existing facilities rather than on new construction. Where the latter would be unavoidable, efforts would be made to ensure that the facilities were located in such a manner as to serve a sufficiently large cluster of communities. In addition, cheaper structures would be designed to reduce costs of construction.

Specific steps would include the formation of an inter-ministerial planning group, composed of the MOE, MLG and MFEP, to prepare relevant proposals; the identification of likely funding sources; and the development of modalities for decentralised implementation. The planning group would be established by mid-1993. The scheme itself would be operational by the end of 1994.

4.3 Improving the Quality of Basic Education

An important task in this area would be to significantly lower the ratio of pupils to textbooks. A preliminary activity would be to assess the magnitude of the shortfall using the annual surveys now being carried out by the MOE. Based on the results, proposals would be prepared for increased production through a one-time injection of capital into the textbook replenishment fund of the MOE. Alternatively, commodity aid could be substituted for the capital injection.

If it is to be effective, greater production would have to be matched by more efficient and timely distribution of textbooks. Three major options would be explored: within the public system, the development of storage and logistical capacity at the regional level; partial privatisation of distribution with the GES retaining responsibility for the most uneconomical "routes", thus, optimising on the relative strengths of the private and public sectors; and complete privatisation in phases.

It is expected that the assessment of the shortfall, increased production of textbooks as well as decisions on the distribution system would be coordinated with the implementation of the Primary Education Programme (PREP) funded by USAID.

As regards the equipping of JSS workshops, particularly in disadvantaged areas, a financing scheme would be developed to complement and sustain the existing efforts of the MOE to provide tool boxes. The aim would be to share the relevant costs among a wide range of contributors including communities, government (national and local), the private sector and NGOs. This may involve a number of different approaches. For instance, regional funds could be established into which contributions in kind and/or cash would be made by the private sector, central government and NGOs. Grants would be disbursed from these funds to beneficiary communities and districts which were willing to co-finance related activities. Alternatively, twinning arrangements might be made between communities and public and private sector companies, established artisanal enterprises and technical training and research institutes to jointly equip JSSs. Relevant proposals on these and other viable options would be prepared by the end of 1993 so that preliminary activities could commence by mid-1994, in time for the 1994-95 academic year.

In the area of instruction, several low-cost initiatives would be launched to both support and assess the performance of teachers. These complementary measures would include the institutionalisation of on-going pre- and in-service training as the basis for regularly upgrading and assessing the skills of teachers. The effectiveness of such programmes would also be evaluated periodically. The training courses would be buttressed through the development and publication of a quarterly *newsletter for principals and teachers*, designed to disseminate ideas and encourage discussion on relevant topics. As a further step to both attract qualified staff and improve performance, proposals would be prepared on the feasibility of merit-based remuneration and promotion of principals and teachers (see Activity 4.6 below). In addition, annual national awards would be instituted for teachers and principals, primarily to highlight their important role in nation-building and, consequently, raise morale in the profession and influence public perceptions.

The impact of improved training as well as the effective operation of merit-based remuneration schemes would depend, to a large extent, on enhanced supervision of teacher performance. Two major activities would be pursued, based upon the system already being established by the MOE for this purpose. The first would involve increased community involvement in the supervision of schools through a revitalisation of Parent-Teacher Associations (PTAs). Thus, communities may be asked to submit a semi-annual report on the operation of their schools as part of the regular supervision and monitoring system at the district level. Such reports would also be used as one of the bases for disciplinary action as well as the retention and promotion of teachers. These community level activities would be reinforced through greater use of the results from assessment tests for pupils. For example, annual league tables on school performance would be published for all schools (by region and district) and be widely publicised including in the teachers' newsletter mentioned above. School performance would also be utilised as a tool for personnel decisions, thus, making school managers more accountable to the public and the MOE.

Among these activities, the publication of the newsletter and the annual awards would commence from 1994. The proposals on merit-based pay would be finalised by early 1994 and implemented, on an experimental basis, in a few selected schools starting in the 1994-95 academic year. The publication of the annual league tables would begin at the end of the 1993-94 academic year while the community reporting system would be operational by 1994.

4.4 Strengthening Links Between Schooling and Employment

The principal activity in this regard would be the restructuring and, in some cases, formalisation of the training opportunities which exist for graduates of JSSs. A key task would be to expand and support the informal apprenticeship programmes which already exist in the country (World Bank, 1989b).

The achievement of literacy and numeracy as well as pre-vocational skills among graduates would be a pre-requisite for the success of such an initiative. Additional steps would, however, be taken to assess the adequacy and relevance of rules and regulations (for example, the National Apprentice Regulations); reassess

the role of the principal technical institution in this area, that is, the NVTI; and increase the ability of craftsmen to impart relevant skills by providing them with training and, depending on resource availability, necessary tools and equipment as incentive goods.

Further measures would include the development of closer links between farmers/fishermen, the agricultural extension service and schools, to increase the involvement of practitioners in the agricultural component of the JSS curriculum. The contacts established while students are still in school would be followed-up through a scheme for placing students with farmers/fishermen willing to impart skills in return for the students' labour. With appropriate modification of school calendars already underway, such schemes could operate during the peak periods of farming.

Another critical component would be a restructuring of the more than 40 governmental technical and vocational training institutes to ensure that the duration as well as content of the training provided by them is consistent with conditions in the labour market. With modest or even no additional investment of resources, these institutes could substantially increase their enrolment of JSS graduates.

Consistent with the recommendations made above, the MOE would initiate contacts with the NBSSI and relevant NGOs on the possibilities of creating a programme to provide financial and technical assistance to graduates of the apprenticeship schemes as well as the technical institutes. The purpose of such a programme would be to provide start-up capital to graduates so that they could establish themselves in farming and the informal sector. This type of assistance would be particularly helpful given the difficulties that graduates are currently experiencing in obtaining funds from other sources.

In view of the complexity and importance of activities in the area of training and employment, a study would be commissioned by the MOE in 1993 to assess the impact of a programme already being pursued in this area. The study would be completed by the end of the year. Depending on the results and a final decision by the Ministry, the programme would be modified, if necessary, and expanded by mid-1995. It would be fully operational by the 1996-97 school year.

4.5 Focusing Efforts on Disadvantaged Groups

Targeted, small-scale projects of 3 years' duration would be developed to reach groups whose needs are currently not being addressed adequately by formal basic education. These projects would be experimental in nature and managed by NGOs. Depending on the outcome of the initial experiments, they would be scaled up, in phases, into national programmes.

A principal target group would be the large number of girls who have never attended or have dropped out of school, especially in the northern parts of the country. This problem would be tackled through adaptation of successful approaches used in other parts of the developing world, such as the BRAC model in Bangladesh, which can provide a "bridge" to the eventual integration or reintegration of the target group into the formal system. Preparatory to the formulation of a project proposal, exploratory investigations would be carried out on several critical issues: the attitudes of parents and traditional leaders; the required involvement of parents and the community; the structure and content of the proposed curriculum; the development of teaching and learning materials; recruitment, training and remuneration of teachers; and the operational characteristics of the schools, for example, the necessary ratio of pupils to teacher. Once the investigative phase is completed, the project proposal would be prepared with implementation focused on three selected communities in each of the northern regions. It is expected that the project proposal would be finalised and funded by mid-1994. Implementation would begin in 1995.

Another target group would be the students of Islamic schools, particularly in the north, for whom religious instruction may be the only form of education. A preliminary activity would be the initiation of discussions with national and local Muslim leaders to assess their interest in an effort to add an element of secular instruction, especially literacy, numeracy and life skills, to religious education. Depending upon a successful outcome to these discussions, a project proposal would be developed in cooperation with the religious

leadership. As with the project on girls' education, this proposal would require a period of investigation touching upon many of the same issues as noted above. The preparatory phase would be completed by mid-1994 followed by implementation in three selected communities in the Northern Region in 1995.

With regard to shepherd schools, they are currently run privately, catering to rural children of primary school-going age in the northern part of Ghana who help their parents to tend livestock. While these schools are well-adapted to the circumstances of the target group, the quality of education provided remains doubtful. Thus, efforts would be made to improve the quality of instruction and, where feasible, absorb the schools into the formal system. A first step in this direction would be the registration of such schools. Upon registration, those with a sufficiently large enrolment would be fully absorbed into the public education system. Smaller schools would benefit from selective assistance in the form of training for teachers and the provision of appropriate learning materials and supplies (as an annual grant). The expectation is that these initiatives would enable shepherds to successfully sit for the normal assessment tests of the MOE.

Finally, concerning illiterate women, the emphasis would be on exploiting existing activities rather than on establishing a new programme. As a result, the scope of the Non-Formal Education (NFE) Programme would be expanded so that a larger number of women in the relevant age group could be enroled in functional literacy classes. This would necessitate financial assistance to train increased numbers of facilitators as well as produce additional literacy and post-literacy materials.

4.6 Improving Management of Education Services

The management of education services would be improved through a three-pronged effort. One element would be to ensure the successful decentralisation of the MOE's operations. This has already begun with the appointment of District Directors of Education in eighty districts in the country, which is expected to be the first step in the establishment of fully functioning District Education Offices. The latter objective will be difficult to achieve, however, primarily because of the limited capacity of the MOE to finance the recurrent costs involved. In order to address these and other issues related to decentralisation, a strategy for resource mobilisation would be identified as the central component of a programme of assistance to the Education Offices. This programme would aim to establish a minimum level of operational capability at the district level.

The strategy would suggest possible funding options which could include, among other things, cost savings in the recurrent budget; cost-sharing arrangements with district authorities; and a debt-for-education swap. The other elements of the programme of assistance would be concerned with the training of personnel, the provision of technical assistance in organisational management and logistical support for basic office operations. The programme proposal would be finalised by mid-1994 for implementation in 1995.

The second element of the effort to improve management would centre on developing more effective conditions of service for teachers and principals. The focus would be on two main areas: basing remuneration as well as promotion on merit/performance and compensating staff, financially and/or in terms of accelerated promotion, for working in particularly difficult areas. Both of these changes would create a more rational and transparent basis for the determination of salaries and career advancement. They would also improve incentives for better performance.

Nevertheless, these reforms could be fraught with difficulties. Taking the latter factor into account, the MOE, in collaboration with the teachers' unions, would commission a study to identify the structure and operational modalities of such an innovative system. Contingent on a decision by the MOE, the system would be implemented, on an experimental basis, in a selected number of schools or districts. The study would be completed by early-1995 so that implementation could commence in late-1995.

The final element would be the strengthening of the management information system (MIS) in the MOE. Such a system would be designed to monitor the educational status of children (by gender, age, location and economic, social and cultural background) as well as yield information on critical operational parameters. The Planning, Budgeting, Monitoring and Evaluation (PBME) Division of the MOE would, therefore, be provided technical assistance to design, develop, test and establish a simple and integrated MIS to be used for the regular collection of data on key indicators at the different levels of the educational system in the country.

The proposed MIS would build upon and incorporate activities already on-going such as the annual educational census. It is expected that the operation of the system would be supported through limited increments in the recurrent expenditures of the PBME Division.

The activities described have been prioritised on the basis of the following considerations: complementarity with the education reform programme in terms of filling identified gaps; responsiveness to the needs of particularly disadvantaged groups; sustainability; and cost-effectiveness. Using these criteria, the cluster of priority activities would include 4.2, 4.3 and 4.5.

5. Programme Monitoring

Completion of programme activities within the stipulated deadlines would be the principal indicator for monitoring implementation in the overall context of the National Programme of Action. This would, however, be supplemented with additional indicators for assessing the scale and effectiveness of programmes. They would be in the following categories: inputs - budgetary allocations and expenditure, human resources (training as well as recruitment), physical facilities rehabilitated or constructed, volume of supplies and equipment; outputs - enrolments; and impact - percentage completing primary schooling, learning achievement among the relevant age group (9-15 years of age) and literacy among the relevant age group. In addition, data would be collected on various measures of educational quality and efficiency of service provision, for example, the number of pupils/textbook, average size of classes, percentage of trained teachers, percentage of repeaters, pupils/teacher and classrooms/school.

Data on inputs would be available from the internal records of the MOE, principally at the national level, supplemented by additional information from districts. Information on outputs as well as educational quality and efficiency would be obtained from the annual census carried out by the MOE. Finally, data on most of the impact indicators would be obtained from periodic surveys such as the proposed survey on social indicators, based on the GLSS and/or the GDHS, which would be carried out every five years.

6. Programme Management

The MOE would be responsible for managing the Education Programme. The headquarters level would be responsible for policy formulation, programme development, budgeting, technical assistance to lower levels of the educational system, donor coordination and overall monitoring and evaluation of the programme. Implementation tasks would be shared between the national and district tiers of the Ministry. In specific cases, responsibilities would be shared in the different areas of programme management with other institutions. For instance, policy formulation on pre-school education would be carried out jointly with the GNCC and MMSW; the community financing scheme for the rehabilitation/construction of primary schools would be developed and executed in collaboration with the MLG and MFEP; vocational training programmes would be designed and executed in cooperation with the MMSW; and, finally, the targeted programmes for disadvantaged groups would be prepared and implemented with the assistance of NGOs.

7. Programme Budget

The budget for the first five years (1993-97) is shown in the summary table below.

NATIONAL PROGRAMME OF ACTION ON THE FOLLOW-UP TO THE WORLD SUMMIT FOR CHILDREN
CAPITAL AND RECURRENT COSTS FOR 1993-1997
(IN USD 000' AT 1992 PRICES)

COMPONENT: EDUCATION PROGRAMME
SUB-COMPONENT: SUMMARY

CAPITAL COSTS

INPUT	UNIT	PHYSICAL QUANTITIES						UNIT COST	CAPITAL COSTS					TOTAL	% OF TOT
A. CIVIL WORKS		PY1	PY2	PY3	PY4	PY5	TOTAL		PY1	PY2	PY3	PY4	PY5		
PRE-SCHOOL															
1. Rehabiliation	no.	-	50	150	325	200	725	2	-	100	300	650	400	1450	
2. New	no.	-	2000	2000	2000	2000	8000	4	-	8000	8000	8000	8000	32000	
3. Upgrading NTC	no.	-	-	-	-	-	-	-	-	100	250	-	-	350	
PRIMARY															
1. Upgrading		-	20	20	50	30	120	2	-	40	40	100	60	240	
2. New		-	175	175	175	175	700	20	-	3500	3500	3500	3500	14000	
Sub-Total										11740	12090	12250	11960	48040	
B. EQUIPMENT															
1. Typewriters	no.	-	61	60	-	-	121	2	-	122	120	-	-	242	
2. Computers	no.	-	2	-	-	-	2	10	-	20	-	-	-	20	
3. Photocopiers	no.	-	6	-	-	-	6	6	-	36	-	-	-	36	
4. JSS Workshop	no.	-	-	-	-	-	-	-	500	500	500	500	500	2500	
Sub-Total									500	678	620	500	500	2798	
C. SUPPLIES FOR															
1. Typewriters	no.	-	-	-	-	-	-	-	-	11	11	8	8	38	
2. Furniture	no.														
a. Pre-Schools	no.	-	2000	2000	2000	2000	8000	0.01	-	20	20	20	20	80	
b. New Primary Schools	no.	-	175	175	175	175	700	17.5	-	3062	3062	3062	3062	12248	
3. Teaching Aids	no.	-	-	-	-	-	-	-	-	300	300	300	300	1200	
Sub-Total										3393	3393	3390	3390	13566	

INPUT	UNIT	PHYSI CAL				QUANTITIES		UNIT COST	CAPITAL		COSTS			TOTAL	% OF TOT
D. TECHNICAL ASSISTANCE		PY1	PY2	PY3	PY4	PY5	TOTAL		PY1	PY2	PY3	PY4	PY5		
1. Long Term	p/m														
a) External	p/m														
b) Local															
2. Short Term															
a) External	p/m	7	5	-	-	-	12	6	42	30	-	-	-	72	
b) Local	p/m	16	9	6	-	-	31	3	48	27	18	-	-	93	
Sub-Total									90	57	18	-	-	165	
E. TRAINING/ ATTACHMENTS															
1. Workshops/Courses	p/w	-	2000	3250	2000	3250	10500	0.1	-	200	325	200	325	1050	
2. Long Term	p/m	-	-	-	-	-	-	-	-	-	-	-	-	-	
3. Attachments	p/m	-	5000	10000	10000	10000	35000	0.003	-	19	37	37	37	130	
4. Manuals/Materials	no.	5000	8000	9000	8000	4000	34000	0.01	50	80	90	80	40	340	
Sub-Total									50	299	452	317	402	1520	
F. VEHICLES															
1. Four Wheel Drive	no.	3	3	4	-	-	10	20	60	60	80	-	-	200	
2. Motor Cycles	no.	-	-	110	-	-	110	1.5	-	-	165	-	-	165	
Sub-Total									60	60	245	-	-	365	
G. OTHERS															
1. Newsletter	no.	-	80000	80000	80000	80000	320000	0.001	-	80	80	80	80	320	
2. National Awards	no.	-	222	222	222	222	888	0.2	-	45	45	45	45	180	
3. Loans for Artisans	no.	-	1250	2500	2500	2500	8750	0.2	-	250	500	500	500	1750	
4. Indus. Tg. for JSS Grad.	no.	-	5000	10000	15000	20000	50000	0.1	-	500	1000	1500	2000	5000	
5. Text Book Fund	no.	-	-	-	-	-	-	-	1000	-	-	-	-	1000	
6. Non-Formal Education	no.	50000	50000	50000	50000	50000	250000	0.01	500	500	500	500	500	2500	
Sub-Total									1500	1375	2125	2625	3125	10750	
GRAND TOTAL									2200	17602	18943	19082	19377	77204	

RECURRENT COSTS

INPUT	UNIT	PHYSICAL QUANTITIES						UNIT COST	RECURRENT COSTS					TOTAL	% OF TOT
		PY1	PY2	PY3	PY4	PY5	TOTAL		PY1	PY2	PY3	PY4	PY5		
A. Personal Emoluments															
1. Existing Staff	p/m	50	65	60	50	50	275	0.2	10	13	12	10	10	55	
2. New Staff	no.	-	3066	6115	9166	12216	30563	1.1	-	3373	6726	10082	13438	33619	
3. Head Teachers	no.	-	175	350	525	700	1750	1.5	-	262	525	787	1050	2624	
B. LOGISTICS SUPPORT		-	-	-	-	-	-		6	187	195	190	187	765	
C. VEHICLE OP'TG COST		-	-	-	-	-	-		8	8	27	13	12	68	
D. OP'TG COST OF OFFICE		-	-	-	-	-	-		9	9	9	9	9	45	
E. OTHER OP'TG COSTS		-	-	-	-	-	-		5	4	3	5	5	22	
TOTAL RECURRENT									38	3856	7497	11096	14711	37198	

WATER SUPPLY AND SANITATION (WS/S) PROGRAMME

1. Background

1.1 The Problem

The situation analysis has shown that the health status of the population, particularly children and women, is threatened by water- and sanitation-related diseases such as malaria and diarrhoea. These diseases are a major cause of child mortality as well as morbidity among both children and women. Repeated episodes of illness caused by such diseases may also contribute to malnutrition. In addition to the human suffering, there are substantial economic costs in terms of loss of productive capacity and reduced attendance at work or school.

There is significant uncertainty about the actual coverage of water supply and sanitation facilities in Ghana. According to the MWH (1991), it appears that "....30% of the rural population has had an improved water supply system (handpump or piped) installed in their community during the last 20 years." Nevertheless, given intermittent piped service and the inoperability of about 30 percent of the handpumps in the country, the rural service coverage may be as low as 20 percent (ibid). A different set of coverage figures for safe water supply are provided by Dovlo (1990). In his view, 48 percent of the total population had access to safe drinking water in 1980, that is, at the beginning of the IDWSS. Whereas coverage in urban areas, constituting 30 percent of the population, was 93 percent the figure for the remaining 70 percent of the population (that is, rural inhabitants) was only 30 percent. The same source suggests that by the end of the IDWSS, coverage of safe water supply had remained unchanged in urban areas but had expanded considerably to reach 50 percent of the rural population, implying a national coverage of about 63 percent. The GLSS (1989), on the other hand, estimates that in 1987-88, the national distribution of households by source of drinking water was as follows: inside plumbing - 11.9 percent; water vendor or truck - 3.3 percent; natural sources - 51.9 percent; other sources - 33 percent. The figures for rural households were as follows: inside plumbing - 1.1 percent; water vendor or truck - 0.2 percent; natural sources - 70.2 percent; and other sources - 28.5 percent.

With regard to sanitation, the MWH (1991) reports that "....about 60% of the rural population has access to trench latrines, 5% to bucket latrines and 1% to flush toilets; the remainder have no facilities." Dovlo (1990) estimates that at the start of the IDWSS, 58 percent of the urban and 15 percent of the rural populations had access to sanitary excreta disposal facilities, yielding a national coverage of only 28 percent. There appears to have been no change in sanitation coverage, however, by the end of the IDWSS (Dovlo, 1990; Noye-Nortey, 1990). In contrast, the GLSS (1989) estimated that in 1987-88, the national distribution of households by type of toilet used was as follows: flush toilet - 5.6 percent; pit toilet - 53.4 percent; pan/bucket - 14.7 percent; and other - 26.2 percent. The figures for rural households were as follows: flush toilet - 0.8 percent; pit toilet - 64.8 percent; pan/bucket - 5.7 percent; and other - 28.7 percent.

The varying coverage figures for both water supply and sanitation facilities conceal significant disparities within rural areas and between rural and urban areas and regions. Thus, in 1984, coverage of water supply among rural communities with 500-4999 people was estimated to be 70 percent compared to only 15 percent among communities with less than 500 people which represent two-thirds of the rural population (GOG/UNICEF, 1990). More recent information (MWH, 1991) on the coverage of rural water supply in the regions reveals significant disparities. The figures range from a high of 91 percent in Upper West Region to an admittedly implausible low of 4 percent in Greater Accra Region. In fact, the data show that all regions except two (Upper East and West) have rural service coverage of less than 30 percent. Moreover, there is an urban bias in the coverage of both water supply and sanitation facilities across all regions. Nevertheless, it is fair to say that the situation even in urban areas is problematic. Thus, over the years, little attention has been paid to peri-urban areas and migrant communities within urban centres.

Beyond the issue of spatial disparities, it appears probable that the coverage figures from, for example, the GLSS (1989) and Dovlö (1990), overestimate actual access to safe water and sanitation facilities. In the case of water, this may be due to systems which have either broken down or are operating below capacity for lack of maintenance; limited funds for the purchase of fuel for generators and motors as well as chemicals for treatment; insufficient expansion of systems to meet population increases; non-participation of communities in operation and maintenance; rejection of systems by users because of excess iron (Amuzu, 1974) or high salinity

(WRRI, 1990); insufficient awareness and knowledge of the role of water in personal hygiene and health; and inadequate water resources, particularly in the dry season. To elaborate on some of the difficulties encountered, effective "....maintenance is complicated by different handpumps being specified by donor agencies for each project, lack of fuel or funds to procure fuel, lack of motivation due to low salaries, delays in transporting supplies and equipment to district facilities, and corrosive groundwater. Serious problems arise when spare parts are not available. With importation procedures generally taking more than a year and with other delays, as few as 40% of the pumps have been operational at times," (MWH, 1991).

Furthermore, the principal sector institution, the Ghana Water and Sewerage Corporation (GWSC), is not structured to cope with the specific demands of rural water supply (see section 1.2 below). Thus, while the "....planning, construction, operation and maintenance of rural water supplies is integrated into the Corporation at all levels....to facilitate ease of management and administration, it does not allow for the substantial differences in the manner in which the rural and urban sectors must be handled. Financing, management and maintenance systems, tailored for urban operations have been applied to rural areas with minor adjustments yielding unsatisfactory results. The limited number of qualified professional staff within the organization have tended to be concentrated in the urban departments at the expense of the rural sector," (MWH, 1991).

Like water supply, the actual coverage of sanitation facilities is probably less than indicated by statistics. The reasons are as follows (MWH, 1991): the state of disrepair of most urban systems owing to the absence of proper maintenance; inadequate design capacities to cope with increasing populations; shortages of personnel to remove night-soil because of meagre remuneration; insufficient consideration for the social behaviour of societies leading to the under-utilisation and sometimes outright rejection of certain newly introduced systems, for example, the mozambique slab-type latrines in the northern part of Ghana (Brown, 1989); and poor coordination of functions among the many actors involved in the sanitation sub-sector (see below). The effects of this difficult situation are exacerbated by the lack of adequate household waste water and storm water disposal systems and the poor state of refuse collection and disposal. As a result, favourable conditions for disease transmission are often created in the immediate vicinity of habitations.

1.2 Government Policies and Structures

The Government of Ghana (GOG) has made a considerable effort to deal with the problems identified in the water supply and sanitation sector. Within the framework of the Economic Recovery Programme (ERP), it has adopted a number of measures, focused primarily on the GWSC (see below for further details), to increase the coverage and efficiency of services. These include the removal of subsidies to the Corporation; upward revisions in water tariffs to ensure self-financing; restructuring, in line with the decentralization programme, to allow greater management autonomy at the regional and eventually district levels; redeployment of excess labour to reduce operational costs; assignment of responsibility to rural communities for the maintenance of their own water supply and sanitation systems; acceptance of the proposal for a national coordinating body to oversee the planning and implementation of water supply and sanitation projects, particularly for rural areas; and mobilisation of external funding for the rehabilitation and expansion of water supply and sanitation services.

Several programmes, especially the Water Sector Rehabilitation Project (WSRP), have also been launched since the beginning of the ERP. The WSRP is a smaller version of GWSC's $250 million five-year rehabilitation and development programme (1987-92). One of the most important components of the Rehabilitation Project is the National Hand-Dug Wells Programme which began to be implemented in 1986. It involves the provision of good drinking water from hand dug-wells to villages of less than 500 inhabitants. The objective was to construct a total of 10,000 wells, at the rate of 1,667 per year, over a six-year period (1986-1992). As of 1990, however, about 9,400 wells still remained to be constructed. Another major initiative within the WSRP has been the Drilled Hand-Pump Wells Programme which also commenced operation in 1986. The objective of this programme was to drill wells by 1992 for all villages nationwide with populations between 500-2,000. Nevertheless, by the end of 1991, approximately 2,400 wells had been drilled, leaving a balance of about 3,700 for completion by 1992. Other components within the WSRP include: strengthening of the GWSC; improvement and expansion of 37 of GWSC's larger water systems outside the Accra-Tema Metropolitan Area; and technical studies on, for instance, the reduction of unaccounted for water,

revaluation of fixed assets and tariffs. There is, in addition, an Immediate Action Programme (IAP) which is designed to cater for the rehabilitation of pumping equipment in about 60 of the weakest water supply systems while resource mobilization proceeds for the longer-term WSRP.

As for the structure and role of governmental institutions, the principal sector ministry is Works and Housing (MWH) which is responsible for urban development, housing policy and the supervision of a number of parastatals. Among the latter is the GWSC which is the government agency solely responsible for the conservation and distribution of water for domestic, commercial and industrial use. The Corporation is headed by a Managing Director supported by two Deputy Managing Directors in charge of Operations and Finance and Administration, respectively. "....Directors for Operations and Maintenance, Planning and Development, Rural Water Development and each of the ten regional offices report to the Deputy Managing Director of Operations....The Director of Rural Water Development is responsible for formulating RWS policies, planning and implementing new RWS projects, coordinating the activities of NGOs and ESAs, monitoring RWS services and supervising the Drilling Unit. The structure of GWSC at the regional level is essentially the same as at headquarters with Operations and Maintenance, Planning and Development and Rural Water Development....Units reporting to a Regional Engineer and Finance, Administration, and Commercial Units reporting to a Regional Finance Administrator," (MWH, 1991). Both the Regional Engineer and the Regional Finance Administrator report to a Regional Director. Finally, "maintenance of small piped systems and handpumps is carried out by district based staff under the supervision of a District Manager and supported by the Regional O&M Unit," (ibid).

Other key governmental institutions include the Departments of Community Development (DCD) and Rural Housing and Cottage Industries (DRHCI) within the Ministry of Local Government (MLG). The DCD is responsible for "....community animation, mobilisation and education. In addition, the Department's Technical Unit has experience in the construction of roads, buildings, water facilities and Ventilated Improved Pit (VIP) latrines," (GOG/UNICEF, 1991). As the GWSC has limited staff below the regional level, the DCD provides substantial support for the implementation of water and sanitation programmes at the district and community levels. The DRHCI has "....units in all the regions staffed by planners, industrial officers, engineering technicians and artisans working on cooperative housing projects and supervising latrine construction and various cottage industry projects. The units are however poorly staffed and equipped at the district level," (MWH, 1991).

The Ministry of Health "....has three divisions that are involved in the water and sanitation sector: Environmental Health Services, Health Education Services and Epidemiology....The Environmental Health Services Division assists local authorities with organization and operation of refuse and night-soil collection and disposal and enforcement of public health regulations in homes, restaurants, markets and other public places. The Division is also involved in a number of water supply and sanitation projects and the Global 2000 BCCI campaign towards the eradication of Guinea Worm, initially identifying endemic areas.....The Health Education Division is responsible for the development of public health education programs....The Epidemiology Division is involved in the planning, execution and evaluation of control measures against communicable diseases of major public health importance," (ibid).

In the future, however, the District Assemblies and the decentralised departments are expected to take responsibility for the planning, implementation and monitoring of sector activities at the local level. They will be assisted in their task by the national and regional level bodies, especially with regard to the overall sectoral policy framework and technical and financial assistance.

While the institutional structure in the WS/S sector is quite extensive, its operational efficiency and impact are diminished by several problems. These include institutional weaknesses - a poor database for planning and programming, inadequate supervision and monitoring of project implementation and shortages of qualified personnel; insufficient coordination among, and lack of clearly defined roles for, the different agencies; a scarcity of resources to fund what can be capital-intensive and technologically demanding operations; and a low level of community mobilisation and participation, especially of women.

1.3 Non-Governmental and Donor Involvement

A number of NGOs are active in the WS/S sector in Ghana. One of the most active indigenous organisations has been Amasachina which is based in Tamale and has operations in the Northern Region. The National Catholic Secretariat has also taken a lead in addressing the water problems of parish communities. Recent initiatives include the Wenchi Village Water Project in the Brong Ahafo Region and the Bole Parish Water Project in Northern Region. "....During the past five years about 1,000 boreholes equipped with India Mark II handpumps have been installed all over the country by the Church," (MWH, 1991). Another active NGO is World Vision International (WVI) which has "...constructed about half of its planned 750 boreholes with complementary KVIP latrines in the Northern, Volta, Central, Greater Accra, Western and Eastern Regions," (ibid). Other active NGOs include Adventist Development and Relief Agency (ADRA), Anglican Church, Baptist Church, Christian World Service, Canadian Universities Service Overseas (CUSO), Evangelical Presby Church, Global 2000, Presbyterian Church and Water Aid.

With regard to support from the donor community, the "....RWS project in the Upper Regions financed by Canada and the 3,000 Wells Project in the south financed by the Federal Republic of Germany together have constructed about 6,000 boreholes providing water to about 1.5 million persons....In the next phase of their support to the Upper and Northern Regions, Canada is planning to shift to community based management by installing VLOM pumps and training the communities to maintain them....In the last few years, Japan has financed the construction of about 600 boreholes which GWSC is responsible for maintaining. Caisse Centrale de Cooperation Economique (CCCE) of France has recently completed planning the first phase of a two phase project to install 900 water points in the Central Region....Switzerland has earmarked funds for the PAMSCAD hand-dug well program and Denmark is interested in contributing to the rural water and sanitation sector. UNDP is financing several RWS/S projects, one in the Volta Region and the other in the Eastern Region with co-financing by the Netherlands. UNICEF is supporting the construction of 560 hand-dug wells and the rehabilitation of 500 handpumps systems; it is also supporting a latrine program," (MWH, 1991). The World Bank is another major multilateral donor. Other donors (bilateral) include Austria, Italy and the United Kingdom (ODA).

2. Programme Objectives

2.1 Principal Objectives[7]

The principal objectives of the WS/S Programme are to:

(a) Provide "...reasonable access to safe water to all communities that are willing to contribute towards the capital cost and pay for all the operations and maintenance costs of an improved supply....If all communities participate, service coverage in rural areas could reach 90% by the year 2010," (MWH, 1991). Coverage in urban areas would meet or exceed the rural target by the year 2010. The aim would be to ensure that practically every Ghanaian has access to a minimum of 20 litres of safe drinking water per day from a source not more than one kilometre away.

(b) Increase the coverage of facilities for sanitary means of excreta disposal to 90 percent of the rural population by the year 2010. The standard would be any system of disposal between pit latrines at the lower end to flush toilets at the upper end.

(c) Ensure that an increasing proportion of households have waste water and storm water disposal facilities of an acceptable standard (capable of preventing the formation of standing pools of water).

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7. It is difficult to establish a baseline for goal-setting in the WS/S sector, given the uncertainties about existing coverage figures discussed in section 1.1. Among the objectives proposed, (a), (e) and (f) are already stated aims of the GOG. The additional objectives (b), (c) and (d) are consistent with the Government's policies.

(d) Ensure that an increasing proportion of households and communities have an adequate system for the collection and disposal of refuse.

(e) Raise awareness among the population on proper hygiene and environmental sanitation.

(f) Establish "....within the private sector in all regions the capacity to construct low-cost latrines and hand dug wells and to maintain manual and mechanized pumps," (MWH, 1991).

2.2 Geographic Coverage and Target Populations

To maximise service coverage, the GOG would give priority to communities with more than 100 inhabitants. In the specific case of rural water supply, the level of service provision would be determined by the size of communities, as follows: 2000-<5000, piped systems; 500-<2000, machine drilled boreholes with handpumps; and <500, hand-dug wells without handpumps. Strengthened RWS/S activities would be focused initially on a maximum of five selected regions, depending on prevailing service coverages and expected donor financing. It is expected that, in many cases, population and epidemiological considerations - such as the incidence of bilharzia and guineaworm disease - would overlap. Finally, a lower priority within the WS/S Programme would be to address the water supply and sanitation problems of migrant settlements in urban centres and peri-urban areas.

3. Programme Strategies

A linked set of strategies have been identified to achieve the objectives of the WS/S Programme, taking into account on-going and planned projects and programmes. They would include:

(a) Increased physical access to safe water and sanitation facilities: The analysis in section 1.2 above has shown that a number of large-scale programmes, especially the Hand-Dug and Drilled Wells Programmes, designed to increase access to safe drinking water in rural areas, are behind schedule. At the same time, the GOG is expected to prepare a comprehensive Rural Water Supply and Sanitation Programme by 1992/93 which will be tested for an initial three-year period. It is, therefore, proposed that relevant pre-existing programmes and targets be absorbed within the comprehensive RWS/S Programme. As a result, emphasis would be placed on the timely formulation and implementation of the latter programme facilitated by appropriate technical and financial assistance.

With regard to urban water supply, the focus will be on the completion of existing initiatives which could significantly improve coverage in the Accra-Tema Metropolitan Area (ATMA) as well as regional and district capitals.

(b) Enhanced sustainability of WS/S services: In view of past experience, a key challenge would be to sustain any expansion in service coverage. This would be addressed through a four-pronged approach, focused on RWS/S.

Firstly, it would be essential to clarify the institutional framework for the implementation of the proposed RWS/S Programme, to, inter alia, ensure consistency with the GOG's decentralisation policy, define responsibilities, avoid duplication and make the most efficient use of existing institutional capabilities (human, technical and financial).

Secondly, it is evident that a major constraint to the successful completion of on-going and planned interventions is the limited capacity of the GWSC and other public institutions to plan, programme, implement, supervise and monitor far-flung and large-scale activities. They are also unable to ensure proper upkeep of capital equipment and provide specialised maintenance services to communities. These problems are most acute at the regional and district levels. Activities would consequently focus on raising institutional capacity, particularly in the target regions, to ensure a rapid, cost-effective and sustained increase in the coverage of services. The emphasis would be on improved systems for management and monitoring as

well as the development of human resources. A sustained effort would also be made to reduce reliance on public agencies through a substantially expanded role for the private formal and informal sectors in the provision of goods and services.

Thirdly, the increased provision of services would be supported with a **sustainable financing** package using available and potentially new sources of funding. Significant progress has already been made in clarifying the policy framework in this area, especially a crucial decision to make rural communities responsible for part of the capital costs of WS/S facilities as well as their operation and maintenance (O&M) costs. The purpose of this cost-sharing approach would be to enhance community ownership and control over services and develop demand-driven and, thus, more sustainable WS/S programmes. Attention would also be paid to the feasibility of targeted support from budgetary sources for the attainment of a basic level of service provision, support from District Assemblies (in both management and financing) and assistance from non-governmental and donor organisations.

Finally, consistent with the framework for sustainable financing, greater effort would be made to encourage communities to act upon the increased responsibilities which they have been given. **Community participation** would be elicited through intensive mobilisation and education as well as the development and demonstration of low-cost technologies for safe water supply and sanitation (see also (c) and (d) below). Particular emphasis would be laid on the critical role of women and the importance of their participation in WS/S activities as "....users as well as planners, operators and managers of community level services," (UNDP/World Bank, 1991).

(c) Development and diffusion of low-cost and appropriate technologies: The sustained expansion in rural service coverage would be underpinned through the development and diffusion of inexpensive technological solutions adapted to the local hydro-geological, economic and cultural context. As part of this effort, the GOG would "....recommend both a direct action pump and a high lift pump for use in Ghana, not for the purposes of standardization but rather to prevent arbitrary introduction of a new type of pump with each new project and to create a sufficiently large market to warrant local manufacture and private sector distribution of pumps and spare parts," (MWH, 1991). This approach would be underpinned by strengthened local capacity (in the private sector) to engage in major aspects of WS/S activities in the country, as referred to in (b) above. Such a strategy would reduce reliance on expensive and often delayed imported equipment and spare parts as well as achieve better maintenance of facilities. It is expected that both these factors would play an important role in encouraging action by communities.

(d) Intensified mobilisation and education of the population: An important challenge would be to encourage rural communities to carry out their responsibilities for the provision and maintenance of safe water and sanitation facilities. At the same time, greater access would have to be matched by increased awareness of environmental sanitation and hygiene issues.

The approach discussed in (c) would constitute one response to this task. It would be supplemented through community mobilisation and education designed to raise awareness on proper hygiene practices and environmental sanitation and promote the benefits and feasibility of safe water and sanitation facilities. This would create favourable conditions for an increased demand for such facilities, a crucial consideration, given that individual and community action would be the principal means of expanding physical access.

(e) Improved coordination among funding and implementing agencies: While desirable, the contributions of a relatively large number of organisations in the water supply and sanitation sector necessitates improved coordination to make better use of resources and reduce delays in implementation. Since action along these lines has already taken place at the national level, the aim would be to support and extend activities designed to replicate coordinating mechanisms at the regional and district levels.

4. Programme Activities

4.1 Expanding Physical Access to Safe Water and Sanitation Facilities

4.1.1 Rural Water Supply and Sanitation

A key activity would be to finalise the detailed design for the "....National RWSS Programme, based, as necessary, on additional field data collection, case studies of best-practice projects, or practitioners' workshops. The Programme design would take the form of a Strategic Investment Plan and would include detailed plans for the restructuring of GWSC; financing, to include cost estimation, cost recovery procedures and financial arrangements; selection criteria, based primarily on self-selection but taking account of special needs, such as guinea worm prevalence; coordination arrangements, both between sector agencies and between community, district, regional and central levels; training of sector staff, local government, the private sector and community members; other private sector support interventions, such as credit, certification and equipment standardization; software activities, including extension services and social marketing....," (UNDP/World Bank, 1991).

The finalisation of the detailed draft programme would be followed by its adoption and launching at a workshop involving all the interested organisations. A donors' conference would also be called, as part of the proposed workshop or as a separate gathering. It would serve as a forum for obtaining pledges and commitments for the National RWS/S Programme. "....Project preparation, either as vertical slices (region/district) or horizontal slices (by component)...." (ibid) would be undertaken once the detailed design of the Programme was finalised. It is expected that the preparatory work mentioned above would be completed by mid-1993.

As for the scale of the required effort in rural water supply, it has been estimated that an increase in coverage to 90 percent by the year 2010 "....would require an additional 15,000 handpumps and 770 small piped systems for....communities that have populations between 100 and 5,000. In addition, it will be necessary to rehabilitate or replace most of the existing 8,600 handpumps (most have now provided service for more than 10 years), converting them to types that can be repaired by local mechanics," (MWH, 1991). The existing 80 small piped systems would also have to be rehabilitated. These figures could, however, change as a result of the coverage surveys proposed in Activity 4.2.2.

The specific tasks which would have to be undertaken to increase service coverage would include the launching of follow-up community-focused surveys to further assess the existing infrastructure (for both water and sanitation), locate possible groundwater sources, identify the appropriate technological solutions and gauge the degree of community interest. The stage would then be set for actual construction/rehabilitation in a collaborative effort between communities, local artisans and technical teams from the GWSC. In the case of sanitation, sustained promotional activities would be undertaken to encourage communities and individuals to construct communal or household latrines. A similar approach would be pursued for the installation of household waste water and storm water disposal systems as well as the adoption of adequate refuse collection and disposal systems. The envisaged expansion of water supply and sanitation facilities would be made possible through the availability, at the local level, of low-cost and appropriate technology as well as the necessary skills for construction and maintenance (see Activities 4.2.2 and 4.3 below).

4.1.2. Urban Water Supply

Several on-going projects would be completed, each of which is described briefly below.

(a) ATMA Water Supply Rehabilitation and Completion

The project provides for the rehabilitation and capacity expansion of the ATMA system. The completion of on-going expansion works to meet water demand to the year 2001, estimated at 109 million gallons/day (mgd), is the major project objective. Current demand is for 76 mgd while supply is 62 mgd.

(b) ATMA-Kpong-Tema Pipeline Relining and Reinforcement

This project involves studies to assess the feasibility of relining the 54 km 42" transmission main instead of constructing another pipeline.

(c) Regional Capitals' Water Supply

The main thrust of the project is to continue the rehabilitation/limited capacity expansion of existing systems and complete on-going works in all regional capitals. The project scope has, however, been reduced to cover only on-going rehabilitation works financed by ODA, KfW, CIDA and the GOG. A separate project has been created for the rehabilitation and capacity expansion works proposed for the regional capitals under the WSRP.

(d) District Capitals' Water Supply

This project caters for water supply rehabilitation and development in 47 of the 110 district capitals. Twenty-three other district capitals are supplied from their regional capitals while another 18 will be catered for under a newly created category. The remaining 22 districts already have water supply systems in operation.

(e) Minor Water Supply Systems

The project groups together rehabilitation/completion and development works required in pipe-borne water supply systems serving towns other than district and regional capitals. They comprise mainly mechanised boreholes (GW system), surface water treated by "package" treatment plants (PP system) and a few medium capacity treatment plants (MCT systems). The rehabilitation work is designed to restore the systems to their original installed capacities as well as improve their level of service and reliability.

4.2 Ensuring Sustainability

4.2.1 Clarifying the Institutional Framework

"....To implement the strategies and thus meet the National RWSS Programme's objectives, specific institutional arrangements must be adopted. The Ghana Water and Sewerage Corporation (GWSC) is the sole institution with the staff, skills and mandate to guide RWSS development. However, the status accorded to RWSS activities and the staff resources dedicated to them are inadequate. Substantial restructuring of GWSC is therefore recommended, without jeopardizing GWSC's current and future obligations to the urban sector....A separate division for RWSS within GWSC, under a deputy managing director, is proposed. The division would be structured in accordance with government decentralization strategy, with functions at the different levels as follows: central - policy support, planning, resource mobilization; regional - monitoring, coordination, and technical services; and district - support to the district assembly in planning, design, contract preparation and extension....and support to community-level construction of simple water supply and sanitation systems....The Rural Division of GWSC would be responsible for planning all RWSS services provision....in....communities of under 5,000 people. Assistance from the Urban Division may be needed if the system planned cannot be locally managed. Special and explicit arrangements need to be developed and adopted for supporting and sustaining the operation and maintenance of the approximately 80 small piped water supply systems and approximately 8,600 handpumps currently serving populations of less than 5,000 people.

"Other government institutions with important roles to play include:

- Ministry of Works and Housing....in policy adoption, regulation, resource mobilization and national programme monitoring and coordination;

- Ministry of Health....for promotion of sanitation and for health education, supported with specialist services from the regional and central levels;

- Ministry of Local Government....for....district assemblies and unit committees which would have primary responsibility for planning and extension; and

- Department of Community Development....in community mobilization, training and support," (UNDP/World Bank, 1991)

The District Assemblies will play a central role in the National RWS/S Programme. They will be responsible for guiding sector development and supporting communities in their jurisdictions to plan their water supply systems. Whenever possible districts would form "....a RWS/S Unit consisting of community development, water supply, and sanitation specialists....District based RWS/S Units would assist communities with needs assessment and in planning their water supply systems; they would also help form and train water committees, promote good health practices and, after the systems have been built, provide support to the communities upon request; they would also provide information on technology choice and design, and coordinate the training of private area mechanics and local contractors for hand-dug/drilled wells and latrines. District RWS/S Units would prepare annual RWS/S workplans and budgets to be adopted by the assembly, and with the assistance of regional RWS/S staff, package contracts for hand-dug or hand-drilled wells. The Department of Community Development and the Ministry of Health would provide staff to the districts (many of whom are already in place) to help implement the Program," (MWH, 1991).

The private sector, both formal (consulting, contracting and manufacturing companies) and informal (for example, masons and mechanics) would be given an important responsibility in the provision of goods and services while external support agencies (ESAs) would provide financial and technical support. "....With the development of a RWSS policy framework and a National RWSS Programme, ESAs will be able to finance elements of the national programme in a rational and coordinated manner, through the Ministry of Finance and Economic Planning," (ibid). NGOs would also be actively involved within the overall framework of the National RWS/S Programme. Last but not least, women's organizations would be encouraged and expected to address the role and needs of women in the areas of rural water supply and sanitation.

4.2.2 Building Institutional Capacity

One of the most important requirements for better programmes in the WS/S sector would be an improvement in the database for planning and the capacity for monitoring within key sector institutions. Information is currently being generated regularly by different organisations but its relevance, quality and frequency has not been assessed in light of the requirements for more effective management of institutions and programmes. Under these circumstances, a systematisation of information systems could enhance programme quality and operational performance. It is, therefore, proposed that an existing project at the WRRI, on the compilation of data for the operational management of water resources systems in Ghana, be expanded to handle this task.

In addition to providing an inventory of existing data and sources, a major element within the expanded project would be the preparation of proposals for the establishment of a decentralised information system. This system would generate information on, for example, water resources, revenues and expenditure, costs, inventories, number of facilities in use (hand-dug wells, boreholes, piped systems) and changes in coverage. It would deploy a variety of tools for collecting information, relying mostly on internal reporting systems but supplemented by special studies and periodic surveys. With regard to the latter, it is suggested that a periodic survey on social indicators be carried out every quinquennium based on the GLSS and/or the GDHS.

Proposals on data collection and use would be ready by 1992/93 with implementation commencing in coordination with the new RWS/S Programme in 1993/94. Beyond the regular information system, a research plan for the sector would be developed in close association with the technology development programme discussed in Activity 4.3. This could include the following items:

- A survey on the coverage of facilities, disaggregated by region and district (to be commissioned at the latest by 1993);
- Investigations on water quality; and
- Studies on community participation.

Better quality, availability and relevance of data as well as strengthened management information systems would be ineffective without parallel improvements in human resources - to analyze data and formulate, implement and monitor programmes. As a consequence, the National RWS/S Programme would be designed as "....a training program, for all participants: communities, project personnel and their supervisors, trainers, and private contractors and mechanics," (MWH, 1991) as well as administrators and other decision makers at the district, regional and national levels. "....In all some 120 RWS/S Division staff, 200 community development agents, 50 to 100 sanitation specialists, 16,000 community water committees, 250 pump mechanics, 20 hand-dug well contractors employing 200 artisans, and 400 latrine artisans...." (ibid) would be trained.

Additional measures would focus on raising the capacity of the private sector. It is expected to "....undertake all construction and maintenance work as well as make and distribute all water supply equipment. As far as possible this will be done by local private contractors, manufacturers and distributors, with financing and technical assistance provided to facilitate this. Of particular importance will be the establishment of....local capacity to construct hand-dug and hand-drilled wells and latrines, to distribute spare parts, and to establish the local manufacture of a direct action pump. In addition, efforts will be made to increase the number of local machine drilled well contractors....primarily through sale of GWSC's drilling equipment and the use of bidding procedures that favor small local contractors," (ibid).

4.2.3 Developing a Sustainable Financing Package

"The cost of planning and constructing rural water supplies would be shared by the communities (10%), Government (15%) and external financing agencies (75%), with community and ESAs paying the capital costs and the Government paying the operational costs of the RWS/S Units," (MWH, 1991). To elaborate, the GOG would "....finance the operational costs (technical assistance provided to the communities) of the district, regional and headquarters based RWS/S Units. A substantial part of the construction costs (about 160,000 cedis or US$500 per community) would be borne by the community. The remainder would be subsidized by the Government with the assistance of ESAs, since it usually exceeds the financial resources of most rural communities and there is no practical way to recover capital costs from the beneficiaries over a long period....To serve as many communities as possible, Government would only subsidize the cost of basic service; higher levels of service would be encouraged but communities would pay the added cost. In addition, communities would pay all operations, maintenance and replacement costs....Preliminary surveys of willingness to pay for improved water supply by rural communities in Ghana, show that an initial contribution of 160,000 cedis (US$500) for a community of 300 is feasible. This represents 50 to 100% of the cost of a handpump (depending on its type), purchased at a private regional outlet, that is, including all normal commercialization costs," (ibid).

"For handpump-based systems, each community would be fully and solely responsible for the maintenance of the pump, including the collection of charges, the recording and saving of funds deposited and used, and the repair of the pump, either by a trained member of the community or by a private mechanic hired for that purpose. The community would also be responsible for the eventual replacement of equipment; handpumps are made up of different components that wear at different rates, requiring replacement at different times rather than a single lump sum payment for the entire pump. This spreads costs out over time and makes them more manageable....For small piped systems, each community could contract GWSC's Urban Division or a private firm to operate, maintain and/or collect revenues for their system, depending on the community's needs....Depending upon the type of contract the community and GWSC entered, replacement costs would have to be financed either by GWSC or by savings of the community," (ibid).

4.2.4 Encouraging Community Participation

Communities have been assigned a central role in the proposed National RWS/S Programme. It is envisaged that the "....acquisition of an improved water supply would start with the application for financial assistance filed by a community through its district. Before this assistance is granted, the community would be responsible for deciding the type of water supply system and its management. In this process, a water committee would be formed (or its functions included in an existing group), a specialized bank account would be opened and an initial contribution to the capital cost deposited, and other pre-project obligations would be met. During

the planning, construction and follow-up period the community would participate in health education and training and would be responsible for improving environmental sanitation," (MWH, 1991). As has already been noted above, communities would be fully and solely responsible for O&M.

Communities' response to this challenge would have to be encouraged through activities undertaken primarily at the district level. The effort would centre on making low-cost and appropriate technology widely available as well as on the intensification of education and mobilisation efforts (both of which are discussed under Activities 4.3 and 4.4 below).

4.3 Developing and Promoting Low-Cost and Appropriate Technology

The initial activity would be the elaboration of a national technology development and promotion programme to focus efforts and reduce duplication. Within this programme, emphasis would be placed on the development of technologies which make the most efficient use of hydro-geological resources, maximise the use of locally available materials and expertise, reduce costs of construction and maintenance and recognise social realities, especially the role of women as managers and supervisors. Furthermore, while research and development would be spearheaded by the relevant technical institutes of the government and universities (for example, WRRI, the Training Network Centre at UST-Kumasi, the ITTUs), they would actively involve communities, particularly women, at all the relevant stages (development, testing, adaptation and demonstration).

Some of the key areas for further research and development could be small-scale surface water treatment plants for rural use which can provide drinking water of both good taste and appropriate bacteriological quality; effective and low-cost disinfection procedures; alternative forms of water-lifting utilising solar and wind energy; use of augers for well construction; appropriate techniques for siting boreholes; household waste and storm water disposal systems; and the design of sanitation facilities to improve performance and reduce costs of construction. In addition to new technology, existing technologies such as rainwater harvesting, spring boxes and infiltration galleries would be promoted.

As part of the proposed technology development and promotion programme, the GOG would widely publicise recommended technologies for water supply and sanitation. For instance, hand-dug and hand-drilled wells rather than machine-drilled wells would be promoted because they are much less expensive. Moreover, they would be suitable in many of the areas where activities would have to be focused to reach the 90 percent coverage target proposed in section 2.1. As for "....pumping lifts up to 12 to 15 meters, direct-action pumps have proved highly successful. Without a lever-handle or bearings, they are characterized by their simplicity, low-cost and ease of repair, and are ideal pumps for village based maintenance. The Nira AF85 pump has proved very successful in many countries and should become the standard for low-lift applications. In Ghana up to two-thirds of all pumps, i.e. a market of about 13,000 pumps, could be direct-action. Use of these pumps on hand-dug wells would also ensure high quality water, at a price that is competitive with drawing water with ropes and buckets....For pumping lifts up to 45 meters, easy to repair, corrosion resistant high-lift pumps are now available," (MWH, 1991).

With regard to sanitation, the "....Kumasi VIP (KVIP) latrine, that is best suited to urban sites and the Ghana-modified Mozambique VIP latrine that is likely to be better suited for rural areas, are now well known in the country. The generation of demand for latrines has in the past been a problem because of.... high cost; it is therefore important that a range of different cost designs for improved sanitation (from a simple trench to various types of VIP and pour flush latrines) be promoted through the National RWS/S Program both for household and public use," (ibid).

Development and promotional activities on these and other technologies would be undertaken in a selected number of communities, for example, three in each of the five target regions, depending on the range of hydro-geological and socio-cultural conditions which would be addressed as priorities. In these areas, the component of technology development would be paralleled by promotional activities based on the training of artisans and the establishment of small-scale production centres (for instance, to make slabs and parts). The technical element would be supplemented through community education and mobilisation (see Activity 4.4 below).

It is expected that the national technology development and promotion programme would be elaborated by end-1993 with implementation commencing in 1994. Additional sites could be established outside the target regions after 1997.

4.4 Educating and Mobilising Communities

The principal activities would be the development of communications materials (posters, leaflets, charts) and their wide dissemination through the national mobilisation structure. The main objectives would be to raise awareness on the benefits of good drinking water and adequate sanitation, the availability of low-cost solutions and the importance of proper hygiene practices. To the maximum extent possible, information and education on these issues would be coordinated - in design, development, distribution and mobilisation -with other related activities within the National RWS/S Programme as well as other on-going efforts of the MOE, MOH and MLG such as the guineaworm eradication programme. The proposed Advocacy Programme has been designed to address these various concerns.

4.5 Improving Coordination Among Funding and Implementing Agencies

The cost-effectiveness and speed of implementation could be increased through improved coordination. There are two major ways of achieving this objective. Firstly, it would be necessary to clarify the respective responsibilities of the key governmental organisations involved, especially in view of the decentralisation programme. A policy statement on this issue would be essential to fully exploit the possibilities for improved coordination (as discussed also under Activity 4.2.1).

Secondly, a functioning coordinating mechanism would need to be established by building upon the framework that is already being elaborated. This could take place with regard to two distinct functions: funding and technical assistance from donors and implementation. With respect to the former, an Inter-Agency Coordinating Committee for rural water supply and sanitation is already operational at the national level. This body would be designated as the principal forum for the identification and coordination of donor support for rural water supply and sanitation. It would play an important role in channelling donor assistance for the proposed new programme in this area.

As regards implementation, an Inter-Sectoral Coordinating Committee at the national level is already operational, the key members being the GWSC, MLG-DCD and MOH. Efforts are currently underway to replicate the national body at the regional and district levels. In the former case, an appropriate forum could be established through the formation of Regional Inter-Sectoral Coordinating Committees (RICCs) while, in the latter case, the focus could be on the Social Sector and Infrastructure Sub-Committees of the District Assembly. The main activity would be to ensure that the RICCs or their equivalent were operational and the Sub-Committees of the Assembly designated as the district-level coordinating fora in step with the implementation of the National RWS/S Programme. It would be necessary to provide short orientation courses for members and identify funding for clearly defined activities related to monitoring and supervision which would be carried out regularly by these coordinating bodies. The District Capacity-Building Initiative (DCBI) within the PHN Programme would be useful in this regard.

It is clear that the proposed WS/S Programme can be divided into two major components: (a) the RWS/S Programme; and (b) the on-going Water Sector Rehabilitation Project (WSRP). It is, therefore, proposed that these components be implemented in phases as follows:

<u>National RWS/S Programme</u>

The preparation of the National RWS/S Programme consisting of most of the component activities described above is proposed as the highest priority in the WS/S sector in Ghana. This is because of its focus on areas where the vast majority of the population lives including the poor in general and children and women, in particular. The Programme would help to tackle those underlying causes of maternal and

child mortality and morbidity which are related to unsafe water, inadequate sanitation and poor environmental hygiene. It would also contribute to a reduction in the workload of women and children by making WS/S facilities more accessible and reliable. Additional though indirect benefits would be derived from strengthening the capacity of the private sector to participate in manufacturing, distribution, promotion, construction and maintenance.

It is proposed that activities be phased as follows:

Phase I: 1992-93

- Preparation of the detailed design of the National RWS/S Programme (Action: MWH/GWSC with support from donors)

- Adoption and launching of the National RWS/S Programme supported by a donors' conference (Action: MWH/GWSC and MFEP)

- Project preparation by region or component (Action: MWH/GWSC in collaboration with donors)

- Formulation of a National Technology Development and Promotion Programme (Action: MWH/GWSC in collaboration with WRRI, UST-Training Network Centre, ITTUs, GRATIS)

- Completion of a coverage survey on water and sanitation facilities nationally (Action: MWH/GWSC in cooperation with the Ghana Statistical Service)

- On-going education and mobilisation of communities (Action: GWSC, MLG-DCD, MOH, MMSW)

Phase II: 1994-97

- Commencement of RWS/S Programme activities in five selected regions (Action: MWH/GWSC in collaboration with other sector ministries as well as NGOs and donors represented in the Inter-Agency Coordinating Committee)

- Launching of a comprehensive capacity-building effort targeted at the implementation of the proposed institutional framework, training of sector staff and the preparation and execution of a training and certification programme for small-scale contractors and artisans (Action: MWH/GWSC and UST-Training Network Centre, as coordinators)

- Implementation of the National Technology Development and Promotion Programme (Action: as in Phase I)

- On-going education and mobilisation of communities (Action: As in Phase I)

Phase III: 1997-98

This stage "....will begin after Phase One is completed and when Phase Two is well underway, and will be the result of the development of new major investment projects and the realignment of all current projects within the National RWSS Programme," (UNDP/World Bank, 1991). (Action: MWH/GWSC, other sector ministries, MFEP, NGOs and donors)

Water Sector Rehabilitation Project

Phase I: 1992-96

- **Completion of all on-going projects - it is likely, however, that resource constraints would lead to delays necessitating a second phase (Action: MWH/GWSC and donors)**

Phase II: 1997-2001

- **During this phase, unfinished projects from Phase I would be completed (Action: MWH/GWSC and donors)**

5. Programme Monitoring

As with all the other sectoral programmes of action, the benchmarks for overall implementation will be the various activity deadlines mentioned above. These will be supplemented with additional indicators, in the following categories: inputs - financial (GOG budgetary allocation, revenues from cost recovery, annual inflows of external assistance), human (recruitment, training) and physical (equipment and supplies); outputs - the population (total, regional, rural-urban) with access to safe water supply and sanitation facilities, changes in knowledge, attitudes, practices and behaviour; and impact - the incidence of water- and hygiene-related diseases such as malaria, diarrhoea and dracunculiasis.

Information on inputs and outputs would be generated from the existing and improved internal reporting system of the GWSC, supplemented by additional data from the RWS/S Units at the district and regional levels (where functioning), MOH, MLG-DCD and MFEP. Impact assessment would be based on epidemiological data collected by the MOH on a regular basis. Information on coverage may be collected every two years after the initial survey or, preferably, in the context of the proposed periodic survey of social development based on the GLSS and/or the GDHS.

6. Programme Management

At the national level, the WS/S Programme would be managed by the Ministry of Works and Housing through the Inter-Sectoral Coordinating Committee comprising GWSC, MOH and MLG-DCD. In the specific case of rural water supply and sanitation, donor (including NGO) assistance would be channelled through the existing Inter-Agency Coordinating Committee.

The GWSC would continue to be the main agency responsible for water supply in both urban and rural areas. It would also deal with waterborne sewerage in communities where this could be feasible. At the regional level, the GWSC would liaise with the regional administrations as well as other implementing agencies through the Regional Inter-Sectoral Coordinating Committees (RICCs) or their equivalent. The objective would be to jointly plan and implement regional programmes based upon requests from districts. The regional level of the GWSC would also provide technical assistance to and supervise districts.

Planning, implementation and monitoring at the district level would be the responsibility of the rural water supply and sanitation units, where they are operational. These units would cooperate with other organisations through the Sub-Committees of the Assembly which would have been designated as the coordinating bodies. At the lowest level, management would be entrusted to unit committees under the District Assemblies assisted by community water and sanitation committees (or the community health management committee).

7. Programme Budget

The budget for the first five years (1993-97) is shown in the summary table below.[8]

8. The budget for the WS/S Programme is partly based on the estimated cost of the proposed National RWS/S Programme. The latter is expected to require funding amounting to $165 million over a 10 year period or $16.5 million per annum. A large proportion of the aggregate cost, about $60 million, is already financed, leaving $105 million to be funded over the next 10 years. Some discrepancies may appear in these estimates due to changes in inflation and exchange rates since 1991 when the RWS/S Programme was costed.

   With regard to the WSRP, the cost of completion (1990-96) has been estimated at C49.2 billion of which C36.8 billion would be required in foreign exchange. At the beginning of 1990, C11.2 billion had been been secured leaving a total financing gap of about C38 billion of which C7.6 billion was expected from local sources (GOG and GWSC). The foreign currency component of the gap is the subject of on-going negotiations with donors.

NATIONAL PROGRAMME OF ACTION ON THE FOLLOW-UP TO THE WORLD SUMMIT FOR CHILDREN
CAPITAL AND RECURRENT COSTS FOR 1993-1997
(IN USD 000' AT 1992 PRICES)

COMPONENT: WATER SUPPLY & SANITATION (WS/S) PROGRAMME
SUB-COMPONENT: SUMMARY

CAPITAL COSTS

INPUT	UNIT	PHYSICAL QUANTITIES						UNIT COST	CAPITAL COSTS					TOTAL	% OF TOT
A. CIVIL WORKS		PY1	PY2	PY3	PY4	PY5	TOTAL		PY1	PY2	PY3	PY4	PY5		
1. Machine drilled boreholes	no.	750	750	750	750	750	3750	7	5250	5250	5250	5250	5250	26250	
2. Hand-dug/drilled wells	no.	750	750	750	750	750	3750	2	1500	1500	1500	1500	1500	7500	
3. Low-lift handpumps	no.	1500	1500	1500	1500	1500	7500	1.2	1800	1800	1800	1800	1800	9000	
4. High-lift handpumps	no.	800	800	800	800	800	4000	0.7	560	560	560	560	560	2800	
5. Piped systems (new)	no.	77	77	77	77	77	385	60	4620	4620	4620	4620	4620	23100	
6. Piped systems (rehabilitated)	no.	8	8	8	8	8	40	20	160	160	160	160	160	800	
7. Dist.Capitals Water Rehab.	no.	16	16	16	16	18	82	46	736	736	736	736	828	3772	
8. Reg. Capitals Water Rehab.	no.	2	2	2	2	2	10	1000	2000	2000	2000	2000	2000	10000	
9. ATMA Water Rehab.	no.	-	-	-	-	-	-		12000	12000	12000	12000	12000	60000	
Sub-Total									28626	28626	28626	28626	28718	143222	
B. EQUIPMENT															
1. Typewriters	no.	2	-	2	-	2	6	2	4	-	4	-	4	12	
2. Computers	no.	2	-	-	2	-	4	10	20	-	-	20	-	40	
3. Photocopiers	no.	2	-	-	2	-	4	6	12	-	-	12	-	24	
4. Others	no.	-	-	-	-	-	-	-	-	-	-	-	-	-	
Sub-Total									36	-	4	32	4	76	
C. SUPPLIES FOR															
1. Typewriters									1	-	1	-	1	3	
2. Computers									5	-	-	5	-	10	
3. Photocopiers									3	-	-	3	-	6	
Sub-Total									9	-	1	8	1	19	

INPUT	UNIT	P H Y S I C A L					QUANTITIES	UNIT COST	C A P I T A L	COSTS				TOTAL	% OF TOT
D. TECHNICAL ASSISTANCE		PY1	PY2	PY3	PY4	PY5	TOTAL		PY1	PY2	PY3	PY4	PY5		
1. Long															
a) External	p/m	12	-	-	-	-	12	8	96	-	-	-	-	96	
b) Local	p/m	-	-	-	-	-	-	-	-	-	-	-	-	-	
2. Short	p/m														
a) External	p/m	6	7	-	-	-	13	7	42	49	-	-	-	91	
b) Local	p/m	9	12	-	-	-	21	6	54	72	-	-	-	126	
Sub-Total									192	121	-	-	-	313	
E. TRAINING/ ATTACHMENTS															
1. Workshops/Seminars	p/w	86	34	-	-	-	120	0.5	43	17	-	-	-	60	
2. Long Term	p/m														
3. Attachments	p/m														
4. Manuals/Materials	no.														
Sub-Total									43	17	-	-	-	60	
F. VEHICLES															
1. Four Wheel Drive	no.	-	-	10	-	-	10	10	-	-	100	-	-	100	
2.	no.														
3.	no.														
Sub-Total									-	-	100	-	-	100	
G. OTHERS															
1. I E & C	no.	-	-	-	-	-	-	-	-	20	20	20	20	80	
2. Promote Approp. Tech.	no.	-	-	-	-	-	-	-	-	50	50	50	50	200	
3. Site Co-ops	no.	-	-	5	10	10	25	2	-	-	10	20	20	50	
Sub-Total									-	70	80	90	90	330	
GRAND TOTAL CAPITAL									28906	28834	28811	28756	28813	144120	

RECURRENT COSTS

INPUT	UNIT	PHYSICAL QUANTITIES						UNIT COST	RECURRENT COSTS					TOTAL	% OF TOT
		PY1	PY2	PY3	PY4	PY5	TOTAL		PY1	PY2	PY3	PY4	PY5		
A. Personal Emoluments															
1. GWSC RWS Division															
Professional Staff	no.	92	92	92	92	92	460	3.5	322	322	322	322	322	1610	
Support Staff	no.	50	50	50	50	50	250	1.5	75	75	75	75	75	375	
2. District Personnel															
Professional Staff	no.	250	250	250	250	250	1250	2	500	500	500	500	500	2500	
Support Staff	no.	50	50	50	50	50	250	1	50	50	50	50	50	250	
3. GWSC HQRS															
Professional Staff	no.	32	32	32	32	32	160	3.5	112	112	112	112	112	560	
B. LOGISTIC SUPPORT															
C. VEHICLE OPERATING COST															
1. GWSC RWS Division		44	44	44	44	44	220	6.3	277	277	277	277	277	1385	
2. District Personnel (Motorbikes)		250	250	250	250	250	1250	3.31	828	828	828	828	828	4140	
D. OPERATING COSTS OF OFF. EQPT.															
E. OTHER OPERATING COSTS															
TOTAL RECURRENT									2164	2164	2164	2164	2164	10820	

PROGRAMME TO ASSIST CHILDREN IN ESPECIALLY DIFFICULT SITUATIONS (CEDS)

1. Background

1.1 The Problem

There is growing evidence that some children in Ghana are faced with problems which place them in especially difficult situations. There are children who are abandoned or orphaned and for whom there is little relief due to the absence of formal social security and the break-down of support from the traditional extended family system, particularly in urban areas. Other children are physically disabled due to a series of factors, most of which are preventable through immunization and proper perinatal care. There are also others who are mentally handicapped, representing perhaps the most neglected and misunderstood group of them all. These children are often marginalised from the mainstream of their communities and made into objects of pity, a practice which diminishes their productive potential and contributes to low self-esteem.

In the specific case of the girl child, female circumcision is still prevalent in some areas. The practice can lead to complications during childbirth and cause emotional distress. On the other hand, teenage pregnancy has been a significant phenomenon in recent years. It is caused by a combination of economic pressures, which lead to an element of dependency on boyfriends and "sugar daddies", peer pressure and the lack of knowledge on contraception. Another contributory factor may be the absence or ineffectiveness of parental supervision. In some cases, there may even be parental neglect, that is, a failure on their part, individually or together, to cater for the basic needs of children. This may be due to broken homes, disputed paternity and irresponsibility on the part of some men. An additional cause of teenage pregnancy is the custom of early marriages. The net effect of these unplanned pregnancies is to burden the girls and their families with additional and unanticipated financial and emotional burdens, which is quite often not shared by the responsible boyfriends.[9]

On a wider scale, child labour in its various manifestations is still common in Ghana. While this is partly due to unavoidable economic pressures and the demands of the socialisation process, there is little doubt that there are exploitative aspects relating, for example, to the use of children as maid servants, hawkers and cart-pushers. Moreover, working children may be susceptible to drug abuse and acts of delinquency. Another related phenomenon is that of children of school-going age who are on the street during school hours. It appears as if the problem has been worsening in recent years. The children most at risk are orphans, those from broken homes and migrant children.

1.2 Government Policies and Structures

The Government does not, at the moment, have a comprehensive policy to deal with children in especially difficult situations. There are, however, separate initiatives, for example, to reduce the incidence of teenage pregnancy and assist the blind.

With regard to structures, the Department of Social Welfare (DSW) is the principal institut responsible for providing social welfare services in the country. It is under the Ministry of Mobilization and Social Welfare (MMSW). One of this Ministry's current responsibilities is to mobilise the population through the National Mobilisation Programme (NMP) and a framework of Social Mobilisation Committees for Child Survival and Development (CSD). The MOH and MOE also have a significant role to play in the area of CEDS through, for example, their immunisation and family planning programmes and special education schools, respectively.

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9. The response to the problem of teenage pregnancy is outlined, for the most part, in the PHN Programme.

The performance of public organisations active in CEDS is hamstrung by, among other things, a poor database, limited co-ordination among the relevant agencies and between different programmes, out-dated forms of institutional organisation and programme design, scarce human and financial resources, and poor supervision, monitoring and evaluation of interventions. As a result, the enforcement of legal provisions relating to CEDS has also been relatively weak.

1.3 Non-Governmental and Donor Involvement

There is very little data on this subject. Some of the NGOs include the Ghacoe Women's Ministry, Ghanaian Association for Women's Welfare, Rotary International, SOS Children's Village, the 31st December Women's Movement and Wesphallian Children's Village. There appears to be no donor-funded programme/project for CEDS.

2. Programme Objectives

2.1 Principal Objectives

The programme aims to:

(a) Improve knowledge and awareness of the causes and dimensions of the problems afflicting children in especially difficult situations;

(b) Integrate disabled children into the social, economic and cultural life of their communities;[10]

(c) Reduce the proportion of children on the street [quantification will await the results of the baseline study]; and

(d) Significantly improve legal protection for working children.

2.2 Geographic Coverage and Target Populations

The coverage of the programme will depend, to a large extent, on the outcome of research and analysis. Nevertheless, anecdotal evidence suggests that the worst aspects of some of the identified problems - such as children on the street - are found in urban areas, especially the larger cities such as Accra-Tema, Sekondi-Takoradi and Kumasi. Teenage pregnancy and disability, however, are nation-wide phenomena.

The target age-groups are likely to comprise the following: the disabled, 0-18 years of age; children on the street, 5-18 years of age; and working children, under 16 years of age.

3. Programme Strategies

Programme strategies have been identified keeping in mind the integrated nature of the National Programme of Action (NPA). Thus, it is expected that well-distributed growth in the economy coupled with improvements in the quality, relevance and accessibility of basic services (for example, health and nutrition, family planning, education and water and sanitation) would reduce both the scope and intensity of the problems affecting children in especially difficult situations. Nevertheless, given the time lags involved and the nature of CEDS, specific additional measures would have to be taken to ensure an appreciable change for the better.

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10. Physical disability would be prevented through the initiatives/activities proposed in the PHN Programme.

Programme strategies, therefore, include:

(a) Expanded operational capabilities of the DSW: The DSW is the key institution responsible for addressing the problem of CEDS. Yet, it is presently not equipped to fulfil its leading role. The Department would, therefore, be restructured and decentralised as well as supported through adequate allocations of human and financial resources. This would be an essential pre-condition for improved programme design and execution as well as for stronger legal protection of children in especially difficult situations. Similarly, the strengthening of the GNCC suggested in the Advocacy Programme would provide significant additional support to the activities of the DSW in raising awareness of the issues, identifying feasible initiatives, monitoring the status of child rights and enforcing laws (see also below).

(b) Improved data collection and analysis on CEDS: Given the paucity of information on the causes, scale and spatial incidence of the phenomenon, it will be essential to achieve a thorough understanding of the relevant issues to establish the bases for effective advocacy and programme development.

(c) Clarification and strengthening of the legal framework on child rights: Adequate protection of children in especially difficult situations not only necessitates stronger institutional oversight (as discussed in (b)) but also laws more supportive of child rights in terms of uniformity, specificity and coverage (including enforcement). The situation analysis has shown that there are still ambiguities and lacunae in laws as they relate to child rights generally and CEDS in particular. Remedying these shortcomings would create a more favourable context for the effective enforcement of child rights, for example, with reference to child labour and parental obligations for child-rearing.

(d) Improved targeting and design of programmes: In order to achieve greater impact and efficient use of resources, programmes will be targeted, to the maximum extent possible, on the worst-affected groups and geographic areas instead of being dispersed nationally. The various approaches used to reach target groups will also be examined with a view to attaining greater acceptance and use of services.

An important consideration in programme design would be to achieve greater sustainability. This issue would be addressed through the involvement of communities and NGOs in the development, management and funding of programmes or programme components.

(e) Increased access to specialised facilities: While the bulk of interventions will have to be implemented at the community or district level, there will continue to be a need for institutions which can provide specialised care for the mentally and physically handicapped and delinquent. They would provide the referral point for lower-level care and serve as technical and training resource centres for programmes. From a different perspective, efforts would be made to encourage the development of recreational facilities for children - such as park amusement centres, libraries and holiday camps - by both public and private institutions

(f) Increased public awareness on CEDS: To create greater understanding of the scope and negative effects of CEDS and, thus, build public and political support for action, a sustained IE&C campaign would be launched as part of the Advocacy Programme. This initiative would be coordinated with the IE&C component of the other sectoral programmes of action.

4. Programme Activities

4.1 Institutional Capacity Building

This activity would involve a restructuring of the DSW to increase its capacity to design and monitor programmes, provide advice to policy-makers, offer technical assistance to communities and, if needed, NGOs as well as ensure compliance with laws governing child rights. A comprehensive organisational study would be commissioned to suggest the most appropriate structure for decentralised operations, consistent with the on-going ministerial restructuring exercise and the provisions of the Local Government Law (PNDCL 207). The Departmental restructuring would be underpinned by adequate budgetary allocations for recurrent expenditures, especially manpower, office supplies and so forth. As an integral part of these changes, personnel would be trained and a system developed for regular in-service training. The restructuring would be completed by mid-1994.

4.2 Research and Analysis

Research would be commissioned to assess the causes, extent and spatial occurrence of the various manifestations of CEDS. The topics to be tackled would include disability, teenage pregnancy, working children, gifted children and children on the street. In the latter case, a survey would be made of conditions in the main urban areas (Accra and all the other regional capitals as well as the larger district capitals). With regard to the disabled, pregnant teenagers and working children, it would be necessary to launch national surveys to establish a credible baseline. This information collection and analysis phase would be completed by the end of 1993.

4.3 Clarification and Strengthening of the Legal Framework

A study would be commissioned in early-1994 to draw up proposals for strengthening provisions related to child rights in Ghanaian law. It would have four points of reference: firstly, the provisions of the Constitution of Ghana; secondly, the contents of the United Nations Convention on the Rights of the Child; thirdly, the results of the research suggested above, to focus on the most critical issues; and finally, the conclusions of analyses which have already been carried out on the subject by the GNCC. The study would identify plausible legal options and prepare the text of draft modifications and additions to existing laws. The proposals would be reviewed by the Government and submitted for approval to Parliament no later than mid-1995.

4.4 Programme Development

Activities 4.1 and 4.2 above would provide the context for an initiative to develop targeted programmes which would use innovative design to reach children in the worst-affected areas. While it would be difficult to suggest the nature of likely interventions without the benefit of greater data, two examples may be provided of what is intended.

Firstly, with regard to the disabled, efforts would be made to incorporate the concept of community-based rehabilitation. This would entail joint action with communities to design an appropriate format for action and fund the related costs (such as artisanal training, farming - including grants of land for individual or group cultivation - and herding). The objective would be to encourage communities to view the disabled as productive members and sustain activities designed to integrate them into the mainstream of life. Community rehabilitation centres (CRCs) would be established to serve as focal points for rehabilitation and learning. These centres would also serve as places for community meetings and as day-care centres.

Secondly, in the case of children on the street, literacy-cum-job training centres could be set up in or near areas where the phenomenon is most acute. A small stipend would be paid to students, if found to be necessary, as partial compensation for the opportunity costs of attendance. As a further inducement, the educational and training component would be complemented by a job placement/apprenticeship scheme

designed to find employment for students upon "graduation". A programme of this nature would be micro-oriented and labour-intensive and would be best implemented by NGOs. Thus, even if the DSW developed such a programme, it would be sub-contracted for implementation to NGOs.

The two potential programmes discussed above would, in addition, address issues of sustainability and efficiency of resource use by involving communities and NGOs as partners and targeting groups and areas worst affected. They would be executed in phases, starting with a few "experimental" projects in 1993. Depending on the results of these initial steps, there would be an expansion and/or reorientation of programmes by end-1994.

New programmes would not be needed in the other important area of concern, that is, teenage pregnancy. Activities planned under the PHN Programme such as education on family planning and AIDS and an increase in the availability of contraceptives would make a major contribution to the diminution of the problem. Similarly, improved family life education in schools would contribute to greater awareness on the issue among the target group.

4.5 Rehabilitation and Expansion of Specialised Facilities

To achieve an immediate improvement in the quality of care, the existing specialised facilities under the DSW would be rehabilitated. These would include nine rehabilitation centres, one in each of nine regions, and five children's homes. This phase would be completed by end-1994.

The rehabilitation phase would be followed by an expansion in the size and number of facilities, designed to provide a cluster of specialised services for the disabled, delinquent and orphaned in each of the three major zones of Ghana: Northern, Central and Southern. These clusters would also serve to train personnel for, and provide technical assistance to, lower-level facilities such as the CRCs. As part of this activity, a rehabilitation centre would be constructed in the Upper West region and the five existing children's homes would be expanded. Additional facilities would be built, depending on the outcome of the surveys mentioned under Activity 4.2. This expansion programme would be completed by 1997.

With regard to recreational facilities for children, activities would include an examination of current incentives for the establishment of amusement parks and the initiation of a dialogue with entrepreneurs to assess the possibilities for investments in the area. Other steps would encompass the formation of activities clubs in schools, the creation of holiday camps, perhaps under the management of NGOs, and the expansion of community-based facilities such as sports grounds. The Ghana Library Board would also be encouraged to establish children's libraries at the district level. Assistance would be available from District Assemblies and central ministries to pursue these initiatives, possibly in the form of matching grants in cash or kind.

4.6 Advocacy on CEDS

Based on the results of activity 4.2, reports would be prepared for wide circulation and discussion at a series of regional seminars which would culminate in a National Conference on CEDS by 1994. The latter would involve political leaders and officials from all levels of administration, national and international experts on the subject, and representatives of NGOs and donor agencies. The Conference would serve as a forum for mobilising high-level support, assessing the results from the "experimental" programmes discussed in 4.3 above and mapping out strategies and options for the future.

In addition, advocacy efforts would be sustained through the development of various communication materials including videos, posters and leaflets. These would be used as "software" for the IE&C activities of the Advocacy Programme. Articles would also be published in the national press and programmes organised for radio and television. Finally, data generated through the regular reporting system of the DSW and special studies would be incorporated in the biennial State of Ghana's Children Report which would be published by the Ghana National Commission on Children/GNCC, commencing in 1994 (see the Advocacy Programme for details).

In view of the importance of the issues and the low cost of the Programme, it is proposed that all the activities described above should be implemented.

5. Programme Monitoring

The indicators for the overall implementation of this "sector" programme would be the activity deadlines outlined in section four above. These would be supplemented by tracking of inputs such as resource flows, changes in the manpower base and the value and volume of equipment and supplies received. As far as the assessment of outputs is concerned, it would be based on data collected through the regular reporting system of the DSW on the use of facilities and services throughout the country. These would be supplemented through periodic evaluations of programmes and a major mid-term evaluation of the overall "sector" programme in 1997 in order to gauge the impact of various interventions. Follow-up surveys to those identified in activity 4.1 may be commissioned towards the end of the programme period, for example, the year 2001, to provide further information on the impact of the NPA on CEDS.

6. Programme Management

The DSW would be responsible for all aspects of implementation. It would, however, focus on policy and programme development, provision of technical and training services, the monitoring of compliance with laws on CEDS and, generally, with the monitoring and evaluation (M&E) of this "sector" programme. The Department would be assisted in its policy advocacy, law enforcement and M&E activities by the GNCC. To the extent possible, implementation, especially at the field level, would be carried out primarily by NGOs, districts and communities.

7. Programme Budget

The budget for the first five years (1993-97) is shown in the summary table below.

NATIONAL PROGRAMME OF ACTION ON THE FOLLOW-UP TO THE WORLD SUMMIT FOR CHILDREN
CAPITAL AND RECURRENT COSTS FOR 1993-1997
(IN USD 000' AT 1992 PRICES)

COMPONENT: CEDS
SUB-COMPONENT: SUMMARY

CAPITAL COSTS

INPUT	UNIT	PHYSICAL QUANTITIES						UNIT COST	CAPITAL COSTS					TOTAL	% OF TOT
A. CIVIL WORKS		PY1	PY2	PY3	PY4	PY5	TOTAL		PY1	PY2	PY3	PY4	PY5		
1. Rehabiliation of Centres	no.	4	5	–	–	–	9	20	80	100	–	–	–	180	
2. Children's Homes	–														
a. Rehabilitation	no.	1	2	–	–	–	3	20	20	40	–	–	–	60	
b. Expansion	no.	–	–	1	2	–	3	30	–	–	30	60	–	90	
3. Construction of Centres	no.	–	1	–	–	–	1	40	–	40	–	–	–	40	
Sub-Total									100	180	30	60	–	370	
B. EQUIPMENT															
1. Computers	no.														
2. Photocopiers	no.														
3. Typewrtiers	no.														
4. Others--------	no.														
Sub-Total															
C. SUPPLIES FOR															
1. Typewriters	no.														
2. Computers	no.														
3. Phtocopiers	no.														
Sub-Total															

INPUT	UNIT	PHYSICAL QUANTITIES						UNIT COST	CAPITAL COSTS					TOTAL	% OF TOT
		PY1	PY2	PY3	PY4	PY5	TOTAL		PY1	PY2	PY3	PY4	PY5		
D. TECHNICAL ASSISTANCE															
1. Long Term	p/m														
a) External	p/m														
b) Local															
2. Short Term															
a) External	p/m														
b) Local	p/m	44	-	-	-	-	44	3	132	-	-	-	-	132	
Sub-Total									132	-	-	-	-	132	
E. TRAINING/ ATTACHMENTS															
1. Workshops/Courses	p/w	-	25	-	-	-	25	0.5	-	12.5	-	-	-	12.5	
2. Long Term	p/m	-	65	23	-	8	96	0.5	-	32.5	11.5	-	4	48	
3. Attachments	p/m	-	-	-	-	-	-	-	-	-	-	-	-	-	
4. Manuals/Materials	no.	500	-	-	-	-	500	0.01	5	-	-	-	-	5	
Sub-Total									5	45	11.5	-	4	65.5	
F. VEHICLES															
1. Four Wheel Drive	no.	1	-	-	-	1	2	10	10	-	-	-	10	20	
2. Motor Cycles	no.														
Sub-Total									10	-	-	-	10	20	
G. OTHERS															
1. Community Activities	no.								-	-	50	50	50	150	
2. Street Children	no.								-	-	50	50	50	150	
3. I.E. & C.	no.								50	70	-	-	-	120	
4. Experimental Projects	no.								-	-	-	20	-	20	
Sub-Total									50	70	100	120	100	440	
GRAND TOTAL CAPITAL									297	295	141.5	180	114	1027.5	

RECURRENT COSTS

INPUT	UNIT	PHYSICAL QUANTITIES						UNIT COST	RECURRENT COSTS					TOTAL	% OF TOT
		PY1	PY2	PY3	PY4	PY5	TOTAL		PY1	PY2	PY3	PY4	PY5		
1. Staff Costs	p/m	12	12	12	12	12	60	0.5	6	6	6	6	6	30	
2. Vehicle Operating Cost	-								1.5	1.5	1.5	1.5	1.5	7.5	
3. Office Operating Cost	-								1.2	1.2	1.2	1.2	1.2	6	
4. Other Operating Costs									3.8	3.8	3.8	3.8	3.8	19	
TOTAL RECURRENT									12.5	12.5	12.5	12.5	12.5	62.5	

ADVOCACY PROGRAMME FOR CHILDREN AND WOMEN

1. Background

1.1 The Problem

Various studies (for example, Adjei, unpublished, 1988; UNICEF, 1988; GOG/UNICEF, 1990) have noted the low level of awareness on essential subjects in Ghana (for example, proper health, nutritional and hygiene practices) and the prevalence of attitudes and behavioural patterns, sometimes rooted in custom and tradition, which are inimical to the welfare of children and women. These factors can seriously undermine the efficacy of development programmes by, among other things, diminishing the responsiveness of opinion leaders and policy-makers to the concerns of children and women; detracting from the full utilisation of available basic services; contributing to the relative neglect of children in the household or their improper upbringing; and understating the actual and potential contribution of women to the improvement of their communities.

To take a few examples, the distribution of protein-rich foods within the household, especially in rural areas, often favours adult males at the expense of women and children, especially girls. If a child happens to be disabled, it will also have to contend with social attitudes which reinforce feelings of dependency and self-pity. From a different perspective, a "....KAP study conducted by UNICEF in four districts of the country....showed that despite the improved capacity of the MOH to supply immunisation services, public demand was still low," (GOG/UNICEF, 1990), partly due to fears among mothers about side-effects. With regard to women, they are still being denied secure tenure of land even though they are the principal producers of food in the country.

At the same time, there has been growing evidence that it is possible to achieve important developmental goals by mobilising the population through relatively inexpensive advocacy efforts supplemented by IE&C programmes. For instance, there has been a significant reduction in the incidence of guineaworm over the last two years due, in large measure, to an intensive IE&C programme. There is tremendous potential for similar improvements in other areas, for example, in immunisation and the treatment of diarrhoea (through cheap and simple means such as rice water and ORS).

The major constraints on an expansion of advocacy and IE&C programmes include, inter alia, the relatively low penetration of modern media in the country - for example, there is one television set per 621 persons (GOG/UNICEF, 1990), an average which is likely to be substantially worse in rural areas; unfamiliarity among media professionals on children's issues; significant weaknesses in the responsible governmental agencies (see below); and "structural" bottlenecks such as the low level of literacy and the scattered distribution of the population.

1.2 Government Policies and Structures

There are three key public institutions for advocacy on behalf of children and women: the Ghana National Commission on Children (GNCC), the Ministry of Mobilisation and Social Welfare (MMSW) and the National Council on Women and Development (NCWD). A number of other organisations such as the National Youth Organising Committee (NYOC) and the 31st December Women's Movement operate within the broad framework provided by governmental institutions.

The GNCC was established in 1979. It was designed to be the principal government institution for advancing the general welfare and development of children. To that end, the GNCC was assigned three major tasks. Firstly, it was given sole responsibility for making proposals to the government on the "enactment or review of legislation in areas of children's rights, privileges and benefits in Ghana" (AFRCD 66 section 2c). Hence, the enactment of the legislative aspects of the child-related efforts of agencies was consolidated under one authority.

Secondly, the GNCC was granted a coordinating role entailing close collaboration with agencies responsible for implementing policies and programmes for children. Finally, it was tasked to provide encouragement and assistance in establishing and regulating facilities for children such as creches, day-care centres, homes for the disabled, playgrounds and specialised facilities for gifted children. The Commission was also expected to encourage the establishment of centres which would offer diagnostic and welfare services to children.

The MMSW is the principal government institution responsible for social mobilization. In the specific areas of child survival and development (CSD), it has a mobilisation structure at the different tiers of the administrative system. There is, at the highest level, a National Social Mobilisation Committee for Child Survival and Development (NSMC-CSD). The latter committee functions through three standing sub-committees on Communication Support, Outreach and Resources, and Logistics and Mobilisation. It is also replicated at the regional and district levels, yielding a total of 121 such committees throughout the country. These committees are all multi-sectoral in composition and count among their members both governmental and non-governmental organisations.

The National Council on Women and Development (NCWD) was established in 1975 (NRCD 322). Its objectives include advising government generally on all matters relating to the full integration of women in national development at all decision-making levels; serving as the official national body for cooperation and liaison with national and international organizations on matters relating to the status of women; and promoting employment opportunities and carrying out education programmes in such areas as family life. It is also the responsibility of the Council to initiate and coordinate programmes and activities that will benefit women, for example, through increased provision of basic health and education services.

The national secretariat of the NCWD is headed by an Executive Secretary. It is also supported through regional offices in all the regions of the country. In order to achieve its objectives and meet the multifaceted concerns of women, the NCWD has worked closely with other governmental as well as non-governmental organizations which implement various programmes for women. This collaboration has taken place in the areas of policy formulation, data collection, research and information dissemination.

The impact of the three institutions mentioned above has fallen short of expectations and the terms of their mandate. While each body has its particular problems, there are a number of common factors which negatively impinge on all of them. One of these is insufficient manpower. The GNCC, for instance, has only three professional staff members to initiate and oversee advocacy efforts. Moreover, the impact of this small pool of human resources is diminished because staff do not have the necessary academic qualifications and/or training in the issues with which the Commission is concerned.

Like the others, the GNCC is also under-funded: between 1984 and 1991, only 25 percent of budgeted subventions on average were actually received from the government (MFEP, GNCC, 1991). This makes the GNCC unusually dependent on donor assistance, even though it is operating in an area where the government has demonstrated significant interest and made major international commitments. The combination of human and financial constraints are, in fact, particularly acute with the social mobilisation committees. Their members currently possess limited capability to plan, coordinate and monitor the wide-ranging activities indicated in their mandate. In addition, the dearth of recurrent funding hampers even basic office operations.

Some problems also arise because these institutions are thinly spread. The Commission, for instance, has been engaged in implementation in addition to performing its coordinating, monitoring and advocacy functions. A similar difficulty with the NCWD has been resolved by focusing its efforts on two major objectives: firstly, advising government on matters relating to the full integration of women in national development; and, secondly, analyzing the adequacy of plans and programmes designed to raise the living standards of women in rural and urban communities. Both the GNCC and NCWD confront the added challenge of adapting to the realities of the decentralisation programme which is focusing increasing attention on districts as the main level for the initiation and implementation of development activities. Neither of these institutions have well-staffed regional branches let alone district offices. Moreover, they need to reexamine their internal operations to ensure that they are consistent with decentralisation.

1.3 Non-Governmental and Donor Involvement

Information on the activities of NGOs and donors in the area of IE&C/advocacy is limited. Some of the major NGOs include Adventist Development and Relief Agency (ADRA), Rotary and World Vision International. Donors include UNFPA (family life education), UNICEF (social mobilisation), WHO (health education), United Kingdom (health education) and United States (social marketing).

2. Programme Objectives

2.1 Principal Objectives

The principal objectives of the programme are to:

(a) Raise public awareness on the condition of children and women in Ghana as the foundation for action by various partners in development - communities, NGOs, the private sector, the government and donors;

(b) Increase public awareness on the provisions of the Constitution relating to Children's and Women's Rights as well as the contents of the Convention on the Rights of the Child;

(c) Expand demand for and utilisation of basic services such as health and nutrition, family planning, education and water and sanitation; and

(d) Improve the institutional capacity and performance of key public institutions responsible for advocacy on behalf of children and women.

2.2 Geographic Coverage and Target Populations

The Advocacy Programme would operate at two levels with regard to geographic coverage: nationwide in the case of activities designed primarily to achieve objectives (a) and (b); and, to the extent possible, in targeted areas to achieve objective (c), guided by the incidence of various problems afflicting children and women. Thus, in the latter case, advocacy and IE&C on CEDS would be focused, at least initially, on the larger cities. Similarly, activities designed to raise utilisation of health and education services would concentrate on districts with particularly poor performance on basic indicators.

Consistent with the approach towards geographic targeting, the main "groups" to be reached will be the national population to achieve objectives (a) and (b) and specific populations in the case of objective (c). In the former case, emphasis may be placed at the beginning on opinion leaders such as members of the government and public administration generally, traditional and religious leaders, media practitioners and field work^rs of the ministries and NGOs (teachers, extension staff, health personnel). To the extent possible, an ef[illegible] ·ill be made to raise the impact and cost-effectiveness of interventions through improved targeting.

3. P[illegible] ·ime Strategies

[illegible] strategies identified to achieve programme objectives represent an extension as well as adaptation of the appr[illegible] :h embodied in existing programmes. They would involve:

(a) Capacity-building of key public institutions: Given the limited ability of key advocacy institutions to reach both policy-makers and the general population with relevant information and analysis, a sine qua non for intensified public action will be an improvement in their capability to increase knowledge and awareness on key problems. This would necessitate a strengthening of their capacity for data collection and analysis, monitoring, policy planning and coordination.

(b) Sustained mobilisation of allies: In order to keep children's and women's concerns at the top of the political agenda, to give first call on resources to children, opinion leaders and the public would need to be kept informed and involved on a continuous basis throughout the programme period. This process of sustained education and participation would build upon activities already underway.

(c) Increased availability of "software" for advocacy and IE&C: The success of advocacy activities would rest, to a significant extent, on the expanded availability and use of innovative multi-media "software" which can exploit the potential of various channels of communication, both formal and informal. To this end, emphasis would be placed on the diffusion of information through drama, music, publications (leaflets, posters, reports, investigative articles in the papers), videos and radio and television programmes.

(d) Greater integration of IE&C programmes: The impact and cost-effectiveness of IE&C programmes are diminished due to the often parallel activities of different government agencies. A substantial improvement in performance would, therefore, be gained at almost no additional cost through better coordination of efforts - in terms of joint design and implementation of programmes - through fora which already exist for this purpose at various levels such as the District Assemblies and the social mobilisation committees.

4. Programme Activities

4.1 Institutional Strengthening

Ghana National Commission on Children (GNCC)

As a first step in the strengthening of the GNCC, a proposal would be developed on the changes required to enable the Commission to fully fulfil the terms of its mandate, as defined in AFRCD 66. The proposal would critically examine the organisational structure needed by the GNCC to advance the interests of Ghanaian children, especially in view of the follow-up to the World Summit.

With regard to the configuration of the strengthened organisational structure, it is proposed that the GNCC have a national headquarters, as at present, but with the technical, human and financial resources required to adequately perform assigned responsibilities. In addition, there would be regional secretariats headed by a Regional Coordinator with supporting staff. The regional secretariats would oversee the formation and operation of regional and district committees on child-related issues. The personnel of the secretariats would be provided with the requisite training and logistical and financial support. It is also proposed that costs be reduced by designating the GNCC as the sole authority at the national level for the coordination of child-related efforts in Ghana, as was stated in AFRCD 66.

The detailed proposal would be completed by the end of 1992 so that, upon acceptance and modification by the Government, the recommendations would be carried out in 1993.

Social Mobilisation Committees for Child Survival and Development (SMC-CSD)

With the proposed changes in the organisational structure of the GNCC discussed above, it would be necessary to reassess the role of the SMC-CSDs. It is, therefore, suggested that the SMC-CSDs at the regional and district levels be transformed into broader committees for monitoring, advocacy and IE&C on child-related issues. This would enable the Commission to reach into the districts without the costly creation of additional institutions. It is envisaged, for example, that these committees would prepare regular reports on child-related issues for onward transmission to the national headquarters of the Commission. They would also play a key role in organising the annual meetings at the different levels of the administrative system proposed in Activity 4.2 below as well as Chapter Six. The committees would be coordinated by the regional secretariats of the GNCC headed by the Regional Coordinator.

National Council on Women and Development (NCWD)

In view of the restructuring exercise already on-going in the NCWD, activities will be focused on expanding the field presence of the Council, especially at the district level. Thus, limited district level representation will be sought through the appointment of a Programme Officer with one support staff in each of the 110 districts of the country, commencing with those which have been identified as areas of particular difficulty for women. An initial batch of appointments would be made by the end of 1994.

4.2 Advocacy and Mobilisation of Allies

In view of the transition to constitutional government currently underway in Ghana, an intensive programme of activities consisting of orientation sessions, press briefings and debates would be held prior to elections to appraise politicians and political groups on the condition of children and women, the significance of the World Summit for Children and the potential for action. Similarly, a short orientation programme would be organised for newly-elected office-holders. These activities would be undertaken at the national and district levels and would be repeated with the regularity required by the electoral calendar and practice in Ghana.

At the national level, an annual meeting would also be held to review the implementation of the NPA and, more generally, to assess, on a continuing basis, the situation of children and women in Ghana. The purpose would be to focus attention on the issues and maintain momentum behind the Summit follow-up. This meeting would be attended by senior government officials, representatives of non-governmental organisations, experts and donor officials. It would, in addition, precede the national budget preparation process so that any decisions made could be supported financially, if required. The meeting would become, in essence, a budget hearing on behalf of children and women.

In a similar manner, to maintain pressure and ensure the involvement of opinion leaders at the local level in CSD and women's development, an annual meeting would be held in each district for assembly members and senior staff of the district administration including the District Secretary and the heads of decentralised departments as well as representatives from various walks of life such as religious and traditional personalities and leaders of community groups, women's associations and so forth.

The meeting would, it is hoped, provide a forum for examining the status of children and women in the district, assessing progress made over the preceding year and achieving a consensus on future action. This brainstorming would be held prior to the annual budgeting process so that any recommendations made would be properly financed - in effect, the meetings would be similar to budget hearings on behalf of children and women held at the national level. They would, ideally, precede the national hearings so as to communicate local level aspirations and views to higher levels.

The national and district meetings would be organised by the GNCC in collaboration with relevant sector ministries within the SMCs (or their equivalent). Within the committees, however, the main organisers would be the GNCC, NCWD and MMSW. The target would be hold the first such annual meetings in 1993. It would be ideal if they could be organised to coincide with the annual "Child Survival and Development Week". Appropriate awards could also be given at the meetings to deserving groups, individuals, districts and regions who have achieved concrete results in eliminating or reducing problems relating to CSD and women's issues. The SMC-CSDs (or their equivalent) could assist in choosing the deserving recipients.

It should be noted that the activities described above represent a consolidation and reorientation of work that is already underway for the period 1992-95. Furthermore, they would complement and reinforce the more formal institutional processes proposed in Chapter Six.

4.3 "Software" Development

In order to provide inputs into advocacy and IE&C programmes, a major effort would be made to convey information to opinion leaders and the public through a multi-media approach.

A key component of "software" development would be the preparation of a biennial "Report on the State of Ghanaian Children" (RSGC). This would form a basic reference document for wide dissemination throughout the country and to individuals and institutions abroad. It would be based on information and analyses undertaken on a routine or periodic basis by governmental, non-governmental and donor organisations as well as special surveys expressly commissioned for the Report. One of the basic themes of the report would be the adequacy of laws relating to child rights and the extent of their enforcement. It is expected, for instance, that the initial volumes of the RSGC would publicise the proposals for legal reform (on child rights) suggested in the CEDS Programme. The Report would also provide a medium for continuously monitoring the status of child rights and bringing cases of abuse and neglect to the attention of policy-makers and the public. Such an effort would be supplemented by the wide dissemination and discussion of the relevant provisions of the Constitution as well as the contents of the United Nations Convention on the Rights of the Child, translated into all the major local languages.

It is envisaged that the RSGC would provide a counterweight to the economic orientation of policy analysis and prescriptions. The Report would be used as one of the background documents for the annual meetings/budget hearings described in 4.2 above. The first volume of the Report would appear in 1994. Subsequent volumes would be more widely distributed through the production, among other things, of videos, posters and leaflets. The principal agency responsible for the preparation of this document would be the GNCC.

While the RSGC would be used primarily as an advocacy tool, complementary actions will be taken to prepare more focused messages for specific problems such as environmental hygiene, AIDS and CEDS. To the extent possible, the messages would be conveyed in an integrated manner to encourage a holistic perception of problems, avoid inundating the public with a barrage of paper and, not least, to ensure cost-effectiveness. Activities would entail the mass production of booklets, leaflets and posters. Using current production levels as a guideline, an IE&C campaign on CEDS would require 25,000 leaflets and a similar number of posters. Dramas and musicals would also be developed for use by the large number of theatrical groups in the country.

As further support to IE&C efforts, the Ghana Broadcasting Corporation (GBC), in collaboration with the National Film and Television Institute (NAFTI), would be given the responsibility to produce and transmit, as a public service, four documentaries or docu-dramas each year on the plight of children in Ghana. These would subsequently be dubbed on video cassettes and distributed to all 120 district and regional social mobilisation committees and interested governmental and non-governmental organisations. Similarly, the local FM radio stations would be employed to convey messages relevant to their areas. Finally, all the national dailies and weeklies would produce monthly supplements focusing on the problems and prospects of children and women.

The proposals made above with regard to IE&C would entail an expansion and intensification of activities already on-going. It is expected that, allowing a year for preparatory work to be completed, it would be possible to implement the larger programme indicated here by end-1993.

4.4 Integrating the Design and Delivery of IE&C Programmes

The substantial investment which is being made and would be made into "software" development would be wasted in the absence of better performance of "hardware", that is, the actual system for developing and implementing IE&C programmes. This constraint would be addressed by integrating work within the strengthened social mobilisation structure.

Thus, the GNCC would be treated as the principal fora for coordinating the IE&C efforts of different governmental and non-governmental agencies in the area of child survival and development. This would entail the joint assessment of programme needs, including technical, geographic and "beneficiary" targeting; feasible

methods of information dissemination; implementation capacity; the possibilities for integrating messages where problems are related and interventions overlap geographically; and the potential for exploiting existing information channels for multiple purposes such as health personnel and agricultural extension staff.

The aim of this coordinated effort would be to yield policy and programme guidelines which would rationalise the production of "software" as well as the conveyance of messages to the public. It is expected that the guidelines would be modified, where necessary, by regional and district SMCs or their equivalent, to suit local conditions. The latter would also be free to develop and produce their own "software" from local budgets and additional allocations made available by the member ministries.

It should be clear that the social mobilisation committees themselves (or their equivalent) would not be implementing bodies. They would simply provide the fora for coordination and a mechanism for assuring unimpeded communication and information-sharing among members, the monitoring of progress and the assessment of impact. To this end, the quarterly newsletters for the SMCs currently being prepared by the National Social Mobilisation Committee for Child Survival and Development (NSMC-CSD) would continue to be produced throughout the programme period. As is presently the case, the print run would be 5,000 copies each quarter. Aside from the latter, the system described would be implemented by the end of 1993 and become fully operational by 1995.

In view of the importance of IE&C as well as advocacy, the cost-effectiveness of suggested activities and the overall low cost of the Programme, it is proposed that all the activities described above should be implemented.

5. Programme Monitoring

The activity deadlines suggested above would constitute one component of the set of indicators used to monitor overall progress. Indicators for operational purposes would include measures of input flow (such as resource allocation and use, production of "software", numbers of staff trained, purchases of equipment and supplies) and output, for example, the numbers of people reached with messages. The latter category of information would be generated by surveys while the former would be available from the internal records of relevant organisations. Evaluations of impact would seek, among other things, to measure changes in knowledge, attitudes, practices and behaviour through the use of KAPB surveys.

Reporting responsibilities would be assigned by activity, as follows: activity 4.1 - the appropriate organisations (GNCC and NCWD); activities 4.2, 4.3, 4.4 - the SMCs or their equivalent led by the GNCC.

6. Programme Management

Consistent with the suggestions in section five above, the responsibility for programme management would vary by activity. Activity 4.1 would be the responsibility of the relevant organisations (GNCC and NCWD). The execution of activity 4.2 would be primarily a task for the GNCC with support from the SMCs or their equivalent. With regard to activities 4.3 and 4.4, implementation would be shared between the GNCC and line agencies: the former would be responsible for ensuring that the coordinating fora were operating and supported through functioning secretariats while the latter would carry out the actual preparation, production and dissemination of messages.

7. Programme Budget

The budget for the first five years (1993-97) is shown in the summary table below.

NATIONAL PROGRAMME OF ACTION ON THE FOLLOW-UP TO THE WORLD SUMMIT FOR CHILDREN
CAPITAL AND RECURRENT COSTS FOR 1993-1997
(IN USD 000' AT 1992 PRICES)

COMPONENT: ADVOCACY
SUB-COMPONENT: SUMMARY

CAPITAL COSTS

INPUT	UNIT	PHYSICAL QUANTITIES						UNIT COST	CAPITAL COSTS					TOTAL	% OF TOT
A. CIVIL WORKS		PY1	PY2	PY3	PY4	PY5	TOTAL		PY1	PY2	PY3	PY4	PY5		
1.	no.														
2.	no.														
3.	no.														
Sub-Total															
B. EQUIPMENT															
1. Computers	no.	1	-	-	-	-	1	10	10	-	-	-	-	10	
2. Photocopiers	no.														
3. Typewriters	no.														
Sub-Total									10	-	-	-	-	10	
C. SUPPLIES															
1.															
2.															
3.															
Sub-Total															

INPUT	UNIT	PHYSICAL				QUANTITIES		UNIT COST	CAPITAL	COSTS				TOTAL	% OF TOT
D. TECHNICAL ASSISTANCE		PY1	PY2	PY3	PY4	PY5	TOTAL		PY1	PY2	PY3	PY4	PY5		
1. Long	p/m														
2. Short	p/m	-	3	-	-	-	3	3	-	9	-	-	-	9	
Sub-Total									-	9				9	
E. TRAINING/ ATTACHMENTS															
1. Workshops/Seminars	p/w	1090	970	23	-	-	2083	0.27	294	262	6	-	-	562	
2. Long Term	p/m	-	-	-	-	-	-	-	-	-	-	-	-	-	
3. Short Term	p/m	-	-	-	-	-	-	-	-	-	-	-	-	-	
4. Attachments	p/m	-	-	-	-	-	-	-	-	-	-	-	-	-	
5. Manuals/Materials	no.	230	870	-	-	-	1100	0.1	23	87	-	-	-	110	
Sub-Total									317	349	6	-	-	672	
F. VEHICLES															
1. Four Wheel Drive	no.	-	2	-	-	-	2	10	-	20	-	-	-	20	
2. Motor bicycles	no.	10	10	-	-	-	20	1	10	10	-	-	-	20	
Sub-Total									10	30	-	-	-	40	
G. OTHERS															
1. Awards	no.	50	50	50	50	50	250	1.5	75	75	75	75	75	375	
2. I.E.C.	no.								-	50	50	50	50	200	
3. R.S.G.C.	no.	-	1000	-	1000	-	2000	0.01	-	10	-	10	-	20	
Sub-Total									75	135	125	135	125	595	
GRAND TOTAL CAPITAL									412	523	131	135	125	1326	

RECURRENT COSTS

INPUT	UNIT	PHYSICAL	QUANTITIES					UNIT COST	CAPITAL	COSTS				TOTAL	% OF TOT
		PY1	PY2	PY3	PY4	PY5	TOTAL		PY1	PY2	PY3	PY4	PY5		
1. Personal Emoluments															
a. Existing	p/m	18	12	12	12	12	66	0.2	3.6	2.4	2.4	2.4	2.4	13	
b. New	no.	-	-	296	296	296	888	1.2	-	-	355	355	355	1065	
2. Vehicle Operating Cost	n.a.								29	29	29	29	29	145	
3. Office Operating Cost	n.a.	-	-	-	-	-	-	-	-	-	-	-	-	-	
4. Other Operating Costs									20	24	24	24	24	116	
TOTAL RECURRENT									52.6	55.4	410.4	410.4	410.4	1339	

CHAPTER FIVE

Financing the National Programme of Action (NPA)

FINANCING THE NATIONAL PROGRAMME OF ACTION (NPA)

I. Introduction

The first five years (1993-97) of the decade-long NPA (1993-2002) would cost approximately $514 million in 1992 prices[11]. This would consist of about $457 million and $57 million in capital and recurrent expenditures, respectively (Table 5.1).

Of these costs, $180 million is already funded by the Government of Ghana (GOG) and donors as part of on-going and planned programmes. The resource gap would, therefore, amount to $334 million composed of $277 million in capital and $57 million in recurrent expenditures (see Table 5.3, column 2). This implies that one of the key challenges facing the successful implementation of the NPA will be the mobilisation of additional funding. Proposals in this regard are presented in sections III and IV of this chapter, following the brief survey below of developments in public finance since the launching of the ERP in 1983.

Table 5.1

NATIONAL PROGRAMME OF ACTION ON THE FOLLOW UP TO THE WORLD SUMMIT FOR CHILDREN
SUMMARY OF COSTS BY PROGRAMME: 1993 - 1997 (USD 000's, 1992 PRICES)

PROGRAMME	1993	1994	1995	1996	1997	TOTAL
PHN						
Capital	9932	60874	59533	60710	41989	233038
Recurrent	3	147	1426	2646	4001	8224
Sub-Total	9935	61021	60959	63356	45990	241262
EDUCATION						
Capital	2200	17602	18943	19082	19377	77204
Recurrent	38	3856	7497	11096	14711	37198
Sub-Total	2238	21458	26440	30178	34088	114402
WATER/ SANITATION						
Capital	28906	28834	28811	28756	28813	144120
Recurrent	2164	2164	2164	2164	2164	10820
Sub-Total	31070	30998	30975	30920	30977	154940
CEDS						
Capital	297	295	142	180	114	1028
Recurrent	12.5	12.5	12.5	12.5	12.5	63
Sub-Total	309.5	307.5	154.5	192.5	126.5	1091
ADVOCACY						
Capital	412	523	131	135	125	1326
Recurrent	53	55	410	410	410	1339
Sub-Total	465	578	541	545	535	2665
CAPITAL TOTAL	41747	108128	107560	108863	90418	456716
RECURRENT TOTAL	2271	6235	11510	16329	21299	57644
GRAND TOTAL	44018	114363	119070	125192	111717	514360

11. Every effort has been made to cost the proposed NPA in most of its details. Nevertheless, the cost figures should be seen as estimates which provide an approximate idea, in terms of orders of magnitude, of the scale of funding required. More accurate figures would have to await the development of detailed programme and project proposals.

II. Public Finance Under the ERP: 1983-91

The economic crisis of the late seventies and early eighties, caused partly by unsustainable budget deficits which peaked in 1975-79 (Alderman, 1991), led to a dramatic reduction in the Government's ability to mobilise both domestic and external resources for national development. By 1983, the revenue and expenditure ratios (that is, revenues and public expenditure as a proportion of GDP) stood at only 5.5 percent and about 8 percent, respectively, with the latter composed almost entirely of recurrent expenditure on compensation for employees. The resulting deficit was financed domestically (World Bank, 1989c). Low and declining revenue ratios together with falling real GDP and reduced budgetary deficits (since 1979) meant that by the early eighties, real public expenditure was decreasing, seriously impairing the provision of essential public services (Alderman, 1991).

One of the principal objectives of the ERP was to substantially overhaul public finance. In fact, contrary to the experience with orthodox stabilisation and adjustment programmes, the ERP has led to a significant increase in the expenditure ratio[12], from about 8 percent of GDP in 1983 to approximately 14 percent of GDP since 1985 (World Bank, 1989c; communication from MFEP, PAD, 1991). Taken together with an average annual growth rate of 5 percent in real GDP since 1983, the figures reveal a substantial improvement in real public expenditure during the period. This expansion has, however, taken place simultaneously with a reduction in the overall budget deficit (narrowly defined[13]) to less than one percent of GDP since 1986 (except 1990) and a projected surplus amounting to 0.4 percent of GDP in 1991 (World Bank, 1991). The key to this impressive achievement has been a recovery in the revenue ratio to a range of about 12-14 percent of GDP during 1986-91 (ibid), as result of greater economic activity, rationalisation of the tax structure (indirect as well as direct) and improved tax collection.

While the changes noted above are encouraging, there are a number of issues which are cause for concern. Firstly, Ghana's ability to increase public consumption as well as investment (a substantial proportion of which is off-budget) has been made possible, to a significant extent, by external assistance which has helped to close the public investment-savings gap. Both the level and composition of public expenditure (as well as the rate of future growth), therefore, remains vulnerable to fluctuations in aid inflows.

Secondly, it will continue to be necessary in the future to restructure the budget (narrowly defined), to yield greater resources for investment as well as for those items of recurrent expenditure which can contribute to greater efficiency and effectiveness in public services. For example, although the share of development expenditure in the budget increased from a low of 13 percent in 1986 to an average of about 19 percent during 1987-91 (World Bank, 1991), the allocation needs to be larger, if resources are to be found for required investments in social and economic infrastructure. At the same time, the returns from such investments will be reduced without changes in allocation within recurrent expenditure. Thus, data for 1986-89 (GSS, 1991) reveal that more than 67 percent of recurrent expenditure was being allocated, on average, to just three items - compensation for employees (45 percent), interest on public debt (13 percent) and transfers to public boards, corporations and institutions (9 percent) - leaving a limited pool of resources for vital operational expenses (defined as "purchase of other goods and services") and local government. As for the public investment programme (PIP), the share of the social sectors (mainly health and education) has generally remained at about 10 percent of total allocations. This proportion may need to increase, in line with expanded capacity within sector institutions to absorb additional resources.

Thirdly, a major constraint in Ghanaian public finance is the narrow tax base, dependent to a large extent on indirect taxation. Between 1986-90, more than 75 percent of central government revenues were yielded, on average, by export and import duties, excise and sales taxes and company taxes (GSS, 1991). Within this aggregate, approximately half was contributed by taxes on international transactions (import duties, sales taxes on imports and export duty on cocoa). As a consequence, revenues and, by implication, resource allocation remain particularly vulnerable to changes in the volume of exports and their terms-of-trade as well

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12. Excluding capital outlays financed through external project assistance.

13. Excluding capital outlays financed through external project assistance.

as the level of external assistance (which helps to finance a substantial proportion of imports). To compound matters, export taxation remains excessively dependent on cocoa, the price prospects for which are expected to be discouraging in the medium-term. The effects of what are usually significant unanticipated fluctuations in revenues also reveal themselves in the practice of releasing only a part of the budgeted estimates for a ministry during the financial year, adversely affecting both planning and implementation.

Last but not least, despite the significant gains made in recent years, there may be scope for increasing the revenue ratio. The current figure is low compared to the average for sub-Saharan Africa (SSA) though higher than the average for the least developed countries/LDCs (UNDP, 1992). Thus, tax revenues as a proportion of GNP stood at 19.3 percent and 10.5 percent for SSA and LDCs, respectively, in 1989 as against 12.7 percent for Ghana (ibid). It is possible that economic growth, a diversification of exports and continuing efforts to broaden the tax base may lead to an increase in the revenue ratio over the medium-term. Projections by the World Bank (1991) suggest that the ratio could rise to almost 16 percent by 1995.

The Government is making determined efforts to deal with public finance issues through tax reform, more effective tax administration and improvements in the management and efficiency of public expenditure. In the case of tax reform, the principal objectives "....have been to raise revenues while reducing reliance on cocoa and to enhance the contribution of the tax system to growth, by reducing tax rates and broadening the tax base," (World Bank, 1991). Some of the relevant measures have included increases in taxes on motor vehicles and petroleum; reduction in the standard rate of sales tax which was high by international standards; higher relief, wider brackets and closure of some loopholes in personal income taxes; and progressive reduction and standardisation of corporate income taxes (ibid). In addition, "....the Government will complete by June 1992 a comprehensive review of the modalities for replacing the current sales tax with a value-added tax," (MFEP, 1992). These initiatives have begun to yield results: even though the share of taxes on international transactions in revenues remained unchanged during 1988-90, the share of cocoa taxes in total revenue declined from 17 percent to 12 percent (World Bank, 1991). With regard to tax administration, there has been increasing emphasis on automation, training and improved monitoring and analysis.

Complementary to tax reforms, a number of steps have been taken to improve the management of public expenditure such as "....the presentation of the 1992 budget on a broad basis, containing all expenditure provisions, including those financed by external resources, in a single document," (MFEP, 1992); implementation and monitoring of recurrent expenditure norms; strengthened expenditure control; and streamlining and decentralisation of public procurement practices (ibid). In the area of efficiency, the aim has been, among other things, to increase salaries in line with changes in productivity and inflation, reduce staffing levels and support capital investments with adequate provision for non-wage recurrent expenditure (ibid).

III. A Scenario for Domestic Resource Mobilisation

The wellbeing of Ghana's children is, first and foremost, a responsibility of the nation. Thus, if increased resources are needed to finance the NPA, the principal source for them should be Ghana herself assisted, where necessary and feasible, by her partners in development. In fact, the analysis in section II as well as what follows below (and in section IV) show that an alliance for children - bringing together the Government, communities, NGOs, the private sector and donors - would be able to cope with the task.

It needs to be noted that the scenario for resource mobilisation is based on conservative assumptions with regard to four key variables: growth in real GDP, the public expenditure ratio, the inter- and intra-sectoral allocation of public expenditure and the volume and inter-sectoral allocation of external assistance. It is hoped that this approach will enhance the realism of the NPA.

III.1 The Role of Government

The Government's ability to support proposed activities would hinge on the performance of the economy, measured by the growth rate of real GDP. The target set in the most recent Policy Framework Paper/PFP (1992-94) is for an average annual growth rate of real GDP of about 5.5 percent. This compares with an achieved average annual rate of increase of about 5 percent since 1983 (as noted in section II). Since 1985, Ghana's record of growth has allowed public expenditure (excluding external project assistance) to expand significantly in absolute terms without any marked alteration in the share of such expenditure in GDP. The PFP indicates that the expenditure ratio is likely to be remain stable in the medium-term (up to 1994) at around 14 percent of GDP.

In order to assess the potential availability of resources to the GOG, an analysis has been made of projected increases in real GDP, based on the assumption of an average annual growth rate of 4 percent during 1993-97 (Table 5.2). This lower figure has been selected for two related reasons: first, to develop a credible measure for testing the financial feasibility of the NPA; and, second, to build into the financing scenario the possibility of internal and external shocks, by defining what can be achieved in a more difficult macroeconomic environment. The projections show that cumulative incremental GDP over the period would amount to $3,640 million.

To gauge the feasible volume of contributions from the GOG, it has been assumed that the average allocations within public expenditure for the individual social sectors would remain unchanged from the pattern which has prevailed during 1985-90. As a consequence, the relative shares of health, basic education, water and sanitation and other children's/women's programmes (CEDS/Advocacy), expressed as a percentage of GDP, are taken to be 1.2, 2.2, 0.05[14] and 0.01, respectively. In absolute amounts, these proportions provide additional funding of $43.7 million for health, $80.1 million for basic education, $1.82 million for water and sanitation and $0.36 million for other children's/women's programmes (Tables 5.2 and 5.3).

The projections suggest that $126 million could be made available by the GOG without raising new taxes or cutting expenditures in non-social areas. As regards the utilisation of additional public resources, it is proposed that they should primarily finance the incremental recurrent costs of programme activities. This would contribute to the sustainability and, thus, credibility of the NPA.

Finally, it may be a matter of concern that the issue of intra-sectoral allocations have not been addressed. This is the case either because the sectoral allocation presented above includes mostly those items which would be covered by the NPA (for example, basic education) or because the allocation itself is so small that changing intra-sectoral allocations would not make any discernible difference (for example, water and sanitation). The principal exception, however, is health. While primary health care (PHC) is a major area of concern in the NPA, allocations for it amount to only about a third of the MOH's total budget. Nevertheless, the situation may not be as difficult as it seems at first sight since some of the costliest items in the PHN Programme relate to the construction, equipping and staffing of district hospitals. Spending for the latter would be funded from the budget for curative health care as well as donor resources which have already been committed for this purpose. Furthermore, it has been proposed that in the future, a dominant share of additional resources for the PHN sector should be allocated to PHC.

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14. The share of water and sanitation in public expenditure excludes spending by District Assemblies and sanitation activities under the Ministry of Health.

Table 5.2
PROJECTED REAL GDP AND EXPECTED SHARE OF SOCIAL SECTORS: 1993-1997
(IN MILLIONS OF 1992 US DOLLARS)

INPUT	1992	1993	1994	1995	1996	1997	TOTAL
A. PROJECTED GDP	5750	5980	6219	6468	6727	6996	38140
B. INCREMENTAL GDP	-	230	239	249	259	269	1246
C. CUMULATIVE INCREMENTAL GDP	-	230	469	718	977	1246	3640
D. EXPECTED CUMULATIVE INCREMENTAL GDP SHARE OF:	-						
1. Health (1.2%)	-	2.8	5.6	8.6	11.7	15	43.7
2. Basic Education (2.2%)	-	5.1	10.3	15.8	21.5	27.4	80.1
3. Water/Sanitation (0.05%)	-	0.12	0.23	0.36	0.49	0.62	1.82
4. Other Women/Children Services (0.01%)	-	0.02	0.05	0.07	0.1	0.12	0.36

Notes: 1. Real GDP is assumed to grow at 4% per annum over the 1993 - 1997 period. GOG forecast as per recent PFP (1992-94) is 5.5% per annum.

2. Percentage shares of GDP are the average for the period 1985 - 1990. Sector shares are assumed to remain unchanged during the 1993 - 1997 period.

III.2 The Role of Communities

Ghana has a long tradition of communities contributing to the development of their areas through levies on cocoa, coffee and other cash crops or by a flat contribution per adult. Communities are presently contributing to the construction of primary, junior secondary and senior secondary schools. Past as well as current experience indicate that between 70 and 90 percent of the costs of civil works and supplies (such as furniture) for primary schools are borne by communities. This trend is expected to be maintained. Nevertheless, since the NPA has been designed to reduce gender and spatial disparities, most rehabilitation and/or construction of facilities is expected to take place in Northern Ghana. In view of endemic poverty in that area, it is assumed that community contributions may have to be lower at 50 percent of total capital costs.

In the area of health, communities have, for some time, been constructing health centres and posts from their own resources. Community level resource mobilisation has not extended, however, to supporting the construction of district hospitals. This may reflect insufficient mobilisation and coordination of efforts by the Government. With the introduction of District Assemblies, such leadership is now possible. In view of this favourable development, it may become feasible to provide land and other inputs from a district's resource base to support the construction of a district/rural hospital. As a result, it is assumed that approximately 20 percent of the construction costs of district/rural hospitals could be borne by communities.

With regard to rural water supply, communities are currently contributing not less than 10-20 percent of the construction costs of hand-dug wells and bore-holes. Indications are that this level of community contributions could be maintained during the programme period. The proportion of community contributions to total capital costs is also sufficiently low in this particular case not to pose insurmountable difficulties even in the northern parts of Ghana. In line with recent policy decisions, additional resources for funding recurrent costs are expected to be mobilised primarily by communities. As for sanitation, the approach proposed in the

NPA emphasises the construction of both communal and household latrines, the costs of which would be mostly borne privately. The overall magnitude of community contributions, for both water supply and sanitation, would be assessed in detail during the preparation of the National RWS/S Programme.

In conclusion, consideration of the issues discussed above as well as the scale of proposed activities indicate that approximately $61 million could be generated by communities to finance the NPA (Table 5.3).

III.3 The Possibilities for Cost Recovery

One of the key elements of the ERP has been an effort to ensure the sustainability of public services as well as encourage their efficient use through cost reduction and cost recovery. The NPA has been designed with these concerns in mind. Emphasis has been placed on low-cost interventions and it is expected that further opportunities for cost reduction could be investigated during the development of detailed programme and project proposals. As for cost recovery, some ideas have been broached in the individual sector programmes in Chapter Four. It is anticipated that apart from direct community contributions, increases in revenues from user fees would accompany the expansion in infrastructure and services proposed in the NPA. The relevant figures for the three key sectors are as follows:

Health: Since 1985, it has been the objective of the MOH to recover 15 percent of its recurrent costs through user fees. Actual recovery between 1985-90 has, however, averaged around 8 percent of recurrent expenditures (MOH, 1991). Nevertheless, with planned improvements in recovery strategies, it is expected that the figure could rise to 10 percent. The latter proportion has, therefore, been used to assess the possibility of recovering from users some of the incremental recurrent costs associated with the NPA. As indicated in Table 5.3, this would amount to $0.8 million.

Education: Although tuition is free in public primary schools, it is expected that textbook, sports and other fees (totaling about C400/pupil in current prices) would help to defray a small part of the incremental recurrent costs related to proposals in the NPA. The expected contribution from cost recovery is anticipated to be $0.2 million.

Water: An assessment has been made of the potential increases in revenues from user fees as a result of the projected expansion in urban water supply, especially in the Accra-Tema Metropolitan Area (ATMA). It is conservatively estimated that, starting from the third year of the NPA, an extra 30 million gallons/day (mgd) would become available to close the deficit in supply. Approximately 70 percent of the resulting revenue, or $12 million, could be utilised to cover incremental recurrent costs (the remaining 30 percent would cover the costs of incremental electricity and commodities consumption associated with the expansion in supply).

Overall, cost recovery measures could yield a minimum of $13 million to help defray the additional recurrent costs entailed in the NPA.

III.4 The Limits of Domestic Resource Mobilisation

Table 5.3 shows, by sector programme, the amount of funding required, the contributions of the GOG and communities, revenues from cost recovery and the remaining resource gap.

As mentioned earlier, the resource gap for the first five years of the NPA amounts to $334 million. Of this sum, capital expenditures account for $277 million while the associated recurrent costs account for $57 million. The projected total contribution of the GOG and communities towards financing this gap would reach $187 million. Cost recovery would yield another $13 million. Thus, total domestic resource mobilisation would amount to $200 million or 60 percent of the additional funding required. The GOG's and communities' shares would be $126 million and $61 million, respectively. Within the Government's contribution, capital costs would absorb $81 million and recurrent costs the remaining $45 million. In contrast, all of the communities' contri-

Table 5.3
NATIONAL PROGRAMME OF ACTION ON THE FOLLOW-UP TO THE
WORLD SUMMIT FOR CHILDREN: 1993-97

SUMMARY OF FINANCING STRUCTURE (USD '000)

PROGRAME	TOTAL COST	FUNDING REQUIRED	POTENTIAL SOURCES OF FUNDING						FINANCING GAP
			G O G	COMMUNITY CONTRIB.	FEE FOR SERVICE	DONORS	OTHERS	TOTAL	
PHN									
Capital	233038	100271	36300	17000	-	-	-	53300	46971
Recurrent	8224	8224	7402	-	822	-	-	8224	-
Sub-Total	241262	108495	43702	17000	822	-	-	61524	46971
EDUCATION									
Capital	77204	75604	43100	30307	-	-	-	73407	2197
Recurrent	37198	37198	36998	-	200	-	-	37198	-
Sub-Total	114402	112802	80098	30307	200	-	-	110605	2197
WATER/ SANITATION									
Capital	144120	98716	1820	13890	-	-	-	15710	83006
Recurrent	10820	10820	-	-	12051	-	-	12051	(1231)
Sub-Total	154940	109536	1820	13890	12051	-	-	27761	81775
CEDS									
Capital	1028	1028	-	-	-	-	-	-	1028
Recurrent	63	63	-	-	-	-	-	-	63
Sub-Total	1091	1091	-	-	-	-	-	-	1091
ADVOCACY									
Capital	1326	973	-	-	-	-	-	-	973
Recurrent	1339	1339	360	-	-	-	-	360	979
Sub-Total	2665	2312	360	-	-	-	-	360	1952
CAPITAL TOTAL	456716	276592	81220	61197	-	-	-	142417	134175
RECURRENT TOTAL	57644	57644	44760	-	13073	-	-	57833	(189)
GRAND TOTAL	514360	334236	125980	61197	13073	-	-	200250	133986

SOURCE: SUB PROGRAMME FINANCING STRUCTURE SUMMARIES.
( ) Implies potential sources exceed financing required by amount in bracket

bution would be used to fund capital costs. Communities would also bear a proportion of operational costs either in cash or kind. These costs would be defined in more precise terms during advanced planning for implementation.

The financing gap remaining after national contributions would amount to $134 million composed entirely of capital expenditures. The magnitude and structure of the gap to be financed are shown in Table 5.4 (p.122).

IV. A Challenge for International Cooperation

Financing for the residual resource gap of $134 million would necessitate a search for increased donor assistance, debt relief or a combination of both.

At the last meeting of the Consultative Group for Ghana, in May 1991, donors pledged total annual assistance amounting to $970 million for the 1991-93 triennium. If this level of pledging was to be maintained during 1993-97, then total pledges over the period would reach $4.85 billion. Viewed in this context, the total cost of the NPA, the total resource gap and the resource gap remaining after domestic contributions would represent approximately 10.6 percent, 6.9 percent and 2.8 percent, respectively, of total pledges.

While pledges provide a useful indicator of donor interest, a more tangible figure is the volume of assistance which is actually committed to the country. The level of commitments has averaged about $800 million per annum since 1988. Assuming a continuation of this trend during 1993-97, total donor commitments over the period would amount to $4 billion. Thus, the total cost of the NPA, the total resource gap and the resource gap remaining after domestic contributions would constitute 13 percent, 8.3 percent and 3.3 percent, respectively, of total commitments. These admittedly simplified examples reveal that the anticipated costs of the NPA would not necessitate vast new amounts of assistance from donors.

The aggregate figures can, however, overstate the volume of external assistance potentially available for the types of programmes proposed in the NPA. Data from the UNDP (1991b, 1991c) suggest that only 13-15 percent of aid disbursements since the launching of the ERP have been directed towards the social sectors. Using these figures as a guide to future inter-sectoral allocations of aid (albeit new commitments rather than disbursements) indicates that $520-600 million might be committed to the social sectors during 1993-97, substantially greater than the resource gap identified above. While encouraging, this conclusion may be misleading for a number of reasons: first, the cost estimates for the NPA may need to be revised during more detailed development of programme and project proposals; second, the ability of the GOG to fund its share of the costs is contingent on a number of variables not least changes in the volume of exports and terms-of-trade, as mentioned in section II; and finally, the sectoral allocations of aid discussed above refer to global amounts channelled towards social development and, therefore, do not necessarily reflect the shares allocated to areas of concern in the NPA, for example, primary health care and basic education - if global patterns are any guide (UNDP, 1992), then the proportion of aid spent on these areas may be found to be relatively small.

External funding might also be mobilised through debt relief. The precedent for such an approach has already been set in the case of Ghana. The World Bank (1991) estimates that "savings" from debt cancellation or conversion (into grants) by some leading donors - including Canada, France, Germany, the United Kingdom and the United States - amounted to $30 million in 1990 and would remain at that level per annum, on average, during 1991-93. The most recent data (World Bank, 1991a) suggest that there is still some scope for further relief: in 1990, total debt service (principal and interest payments) on long-term bilateral debt amounted to $52 million.

Additional donor assistance could be channelled in innovative ways. For instance, savings in local currency from debt relief can be earmarked for the NPA in the form of a Solidarity Fund. Such a fund could disburse small grants to stimulate and sustain the large number of community initiated and managed activities proposed in the NPA. Another option would be to establish an education endowment for girls to fund scholarships for attendance at junior and senior secondary schools. This endowment could also stimulate innovative programmes to redress gender imbalances in educational achievement in particularly disadvantaged areas. Another approach would be to establish a Social Stabilisation Fund (SSF). This would serve two major

functions: first, it would make funds available to maintain a defined minimum level of social expenditure during periods of internal or external shocks; and, second, in "normal" years, it would provide an additional pool of resources for social investment directed, for instance, to district initiated and managed projects or services. The idea would be to treat the SSF as an investment fund rather than as a one-time capital grant.

V. Sectoral Analysis

Population, Health and Nutrition (PHN)

The sector resource gap amounts to $47 million or almost 35 percent of the residual gap. The major activity entailed is the construction of some district hospitals essential for the smooth functioning of the referral system based on Ghana's PHN strategy. Some training, technical assistance, vehicles for supervision and outreach work plus support for malaria control, ARI activities, AIDS screening, community nutrition programmes and so forth also require financing.

Basic Education

The sector resource gap is $2.2 million, constituting 1.6 percent of the residual gap. Funds are required for equipment, technical assistance and training.

Water and Sanitation

The gap to be financed is $82 million or 61 percent of the residual resource gap. It covers the cost of civil works and equipment associated with a projected expansion in access to safe water supply.

CEDS

The gap to be filled, amounting to $1.09 million, represents approximately 1 percent of the residual financing gap. It covers technical assistance and training plus a small sum for recurrent expenditures (which could be absorbed by the GOG).

Advocacy

Total funding required for this programme is about $1.9 million or about 1.5 percent of the residual resource gap. Approximately $0.98 million is for new staff, a cost which could be supported by the GOG, based on projected resource availability. Funding for the interim would need to be identified, conceivably through increased budgetary allocations. The remaining gap, amounting also to $0.98 million, is mostly for technical assistance and training.

Table 5.4
NATIONAL PROGRAMME OF ACTION: 1993 - 97
FINANCING GAP (USD 000's)

	PHN	BASIC EDUCATION	WATER SANITATION	CEDS	ADVOCACY	TOTAL
CAPITAL	46971	2197	83006	1028	973	134175
RECURRENT	-	-	(1231)	63	979	(189)
TOTAL	46971	2197	81775	1091	1952	133986
PERCENTAGE OF TOTAL	35.1	1.6	61	0.8	1.5	100

( ) Implies potential sources exceed financing required by amount in bracket

CHAPTER SIX

Maintaining the Momentum: Leadership for Action

MAINTAINING THE MOMENTUM: LEADERSHIP FOR ACTION

I. THE TASKS AHEAD

The Declaration and Plan of Action adopted at the World Summit for Children constitute an unique challenge, to the international community and individual nations, to transform commonly accepted goals, which are still statements on paper, into reality for children. A first step in this direction has already been taken by Ghana, and more than 100 other countries in the world, through the preparation of National Programmes of Action (NPAs).

Whatever the final form of Ghana's NPA, a key task will be to entrench its contents as priorities within Government and society. If this is to become a reality, then efforts must be made to elicit sustained support over a ten year period, at both the political and managerial/technical levels, for the achievement of the Summit goals. Such support will be a prerequisite for maintaining the momentum already generated and providing decisive leadership in the implementation of the NPA.

The Government of Ghana has already demonstrated its willingness to take up this challenge. The proposals which follow aim to build upon this foundation by outlining an institutional framework within which activities could be coordinated, progress monitored on a regular basis and timely action taken to correct any problems which may arise in the course of implementation.

II. INSTITUTIONALISING A COMMITMENT TO GHANA'S CHILDREN

The concerns of children and the promises which have been made to them will require the political leadership, public sector managers, NGOs and the general public to become actively engaged in the implementation and monitoring of the Programme of Action, to ensure that these issues become a permanent item on the country's agenda. This desirable outcome can be facilitated through appropriate institutional arrangements, both structural and procedural, designed to place children's concerns firmly in the mainstream of policy and budgetary decision-making and public action. Proposals in this regard are discussed below. They are consistent with reforms which are gradually transforming the system of administration in Ghana as well as with the contents of the Human Development Strategy (HDS). Nevertheless, it should be noted that the final configuration of institutions and processes will depend on the outcome of the on-going transition to constitutional government.

The proposed institutional framework, articulated by the level of administration or participation, is as follows:

a. The Community Level

The proposal envisages a high level of community involvement in advancing the goals for children, as the basic building block for effective and sustained action throughout the country. The specific institutional structures and mechanisms adopted by communities to pursue shared goals would vary depending on social, cultural and economic considerations as well as on the design of governmental and non-governmental development programmes. Some of the options may include traditional councils composed of elders, community health committees and parent/teacher associations.

The principal task for communities, which would depend primarily on their own interest and initiative, would be to establish the basis for joint action. This would, ideally, be attained through an open discussion of problems and prospects culminating in the identification and prioritisation of felt needs. To the maximum extent possible, attention would be drawn to the importance of involving women in the decision-making process, given their role as financiers, managers and users of social services.

Communities' responsibilities would be made more tractable through their direct and indirect participation in discussions and debates within fora such as Unit Committees, Town/Area Councils and District Assemblies. Contacts with the field staff of line departments - for example, health, education and agriculture -

would also be of assistance as would the various information dissemination and advocacy efforts of governmental and non-governmental organisations. These links would be critical to securing a symbiotic, stable and productive relationship between communities and "external" actors, one in which the former would be active partners rather than passive recipients.

Where a consensus has been attained in favour of joint action, communities would need to mobilise local resources to complement assistance available from governmental and non-governmental sources, as has already been successfully achieved in activities within the health and education sectors and PAMSCAD. In addition, child-related projects, such as the construction/rehabilitation of wells, schools and health posts, made possible through this cooperative effort would involve communities in partly managing service provision, especially with regard to the recruitment of staff and contributions in kind or cash towards recurrent costs. Examples would include the operation and maintenance of wells, the maintenance of community registers of vital events and the selection and compensation of community health workers.

Communities, particularly women, would also be actively engaged in monitoring the outcome of their activities and of the assistance received from "external" sources. This function would serve a dual purpose. On the one hand, it would encourage communities to critically assess the success of their own efforts, identify bottlenecks and initiate remedial action, independently or with outside assistance. On the other hand, it would provide a grassroots perspective on the success of projects and, perhaps, achieve greater accountability for service providers, whether public or private (see also section IV below).

b. The District Level

In line with the on-going decentralisation programme and consistent with the Human Development Strategy, the institutional framework being proposed focuses on the progressive strengthening of districts as the level at which social services will increasingly be managed and monitored.

The key institution in the Districts would be the Assembly. Two groups within the Assembly would be particularly relevant: the Executive Committee and the Social Sector Sub-Committee. The former would provide a political forum for generating recommendations to the Assembly on the priority needs of children and related budgetary allocations. Inputs into these recommendations as well as their subsequent scrutiny would be spearheaded by the specialised Social Sector Sub-Committee. Both these Committees would be assisted in their tasks by the District Planning and Budgeting Units (DPBUs) and the offices of the decentralised departments. The Programme of Action proposes substantial investment in capacity building to enable these line departments to perform their tasks more effectively.

There are several major functions which would be performed by district level institutions, under the leadership of the Assembly. They are as follows:

- Mobilisation of broad-based support for priority interventions targeted towards children through dissemination of information, discussions within the Assembly and an on-going dialogue with the public
- Identification of particularly vulnerable groups defined according to national standards of wellbeing for children
- Incorporation of child-related objectives in medium- and long-term perspective plans and associated annual plans of action and budgets
- Mobilisation of resources to fund child-related projects
- Coordination of child-related projects in the various social sectors
- Implementation of child-related projects
- Monitoring of the outcome of projects in active cooperation with communities

c. The Regional Level

The principal task at the regional level would be to mediate between national and district level perceptions of needs and priorities. The institutional focus for this activity would be the Regional Coordinating Council (RCC). Within the RCC, a Sub-Committee on Children, chaired by the Regional Secretary, would provide leadership on the relevant issues. The RCC would be assisted in its work by the line departments represented at that level (including the regional representatives of the GNCC and NCWD) as well as the Regional Planning and Coordinating Units, when they are established.

The following functions would be performed at this level:

- Articulation of children's priority needs as seen from a regional perspective
- Identification of particularly vulnerable areas defined in terms of a national standard of wellbeing for children
- Coordination of child-related projects in the various social sectors
- Monitoring of district spending priorities and outcomes of child-related projects
- Provision of technical assistance and logistical support to districts for the implementation of projects

d. The National Level

At this level, a Sub-Committee of the Cabinet reporting to the Head of State would be established. It would include Secretaries of State from the NDPC, Ministry of Finance and Economic Planning and selected sectoral ministries/agencies. Alternatively, the mandate of an existing Sub-Committee could be expanded, if this is found to be a more efficacious option. The main purpose of this group would be to provide a high level political forum for the follow-up to the World Summit. Specific objectives would be to monitor overall progress towards the goals and provide leadership on issues related to policies, programmes and budgetary allocations.

The Sub-Committee would be supported by a group chaired by the Cabinet Secretariat and including representatives from the GNCC, NCWD, NDPC and the MFEP. This support group would perform its task in liaison with the Planning and Budgeting Divisions of sectoral ministries. In addition, the Sub-Committee of the Cabinet would co-opt eminent persons to assist in its deliberations.

The activities of the Cabinet would be complemented by the future Parliament through one of its Standing Committees or a special Sub-Committee specifically established to address the concerns of children. Such a body would provide an opportunity for wider debate on children's issues and would achieve greater transparency and accountability on matters related to policies and spending priorities. Furthermore, it would help to generate popular interest in and support for the Programme of Action. The Parliamentary Committee or Sub-Committee would, in performing its functions, call upon the services of the institutions mentioned above (the GNCC, NCWD, NDPC, MFEP and sectoral ministries).

While the Cabinet and Parliament would set the broad parameters for action, the specifics of implementation and monitoring would remain the responsibility of key coordinating, financing and sectoral ministries as well as the relevant cross-sectoral Commissions.

In line with the thrust of on-going institutional reforms, the principal objective at the national level would be to create an environment conducive to successful coordination of child-related activities and increasing responsibility for their implementation at the regional and, especially, district levels. The specific tasks which are contemplated and the institutions with primary responsibility for them would be as follows:

- Development Planning: NDPC
- Policy Planning: NDPC, MFEP and sectoral ministries/agencies
- Coordination of Policies and Programmes: NDPC in cooperation with sectoral ministries/agencies
- Programme Development: sectoral ministries/agencies
- Budgetary Allocation: MFEP in cooperation with sectoral ministries/agencies
- Resource Mobilisation: MFEP
- Monitoring and Evaluation: GNCC, NCWD, NDPC, MFEP and sectoral ministries/agencies
- Advocacy: GNCC, MMSW and NCWD

III. DEVELOPING INSTITUTIONALISED PROCESSES

A series of activities would be pursued on a regular basis to institutionalise a continuous process of policy supervision, monitoring and assessment of progress.

At the grassroots, communities would be supported, through improved information dissemination and advocacy, to keep children's concerns high on their agenda and also to initiate action with their own resources without necessarily waiting for "external" assistance. Opinion leaders, such as chiefs, priests/imams, market women and members of voluntary associations, would be urged to discuss children's issues regularly at durbars, masses/friday prayers, meetings of associations, festivals and other public events.

At the district level, an annual meeting of both the Executive Committee and Social Sector Sub-Committee would be dedicated to an examination of children's issues (including their changing status), monitoring of child-related development activities and decision-making with regard to support from the district budget. These meetings would include presentations from line departments, perhaps in the form of a consolidated or joint statement, dealing with the status of children, the progress and outcome of on-going activities and proposals for follow-up action. The Assembly's deliberations would also be reinforced with greater discussion of children's concerns at the numerous public ceremonies which are held every year in a district as well as at the yearly "budget hearings" proposed in the Advocacy Programme (Activity 4.2).

The outcome of discussions at the district level would be communicated to the Regional Coordinating Council as an input into its own annual meeting dedicated to children. As in the districts, line departments would be requested to prepare a consolidated or joint statement providing a regional perspective on the status of children, the progress and outcome of child-related development activities, the bottlenecks encountered and necessary follow-up action. On the basis of its discussions, the RCC's Sub-Committee on Children would identify areas of successful or poor implementation, compile a list of priority problems, indicate the type and scale of assistance required from Central Government, if necessary, and finally outline the support that the Regional Administration could provide to districts over the next budget cycle.

At the national level, there would be semi-annual meetings of the Cabinet Sub-Committee concerned with tasks similar to those performed at other levels. These gatherings would, in addition, concern themselves with strategic issues, especially those related to policy direction and budgetary allocations, which would be designed to set the broad framework for action throughout the country. The deliberations of the Sub-Committee would be based on consolidated reports from the regions as well as inputs from its secretariat in the form of a national overview of the changing status of children, progress in the implementation of the NPA and bottlenecks which may have been encountered over the reporting period. The secretariat would also make recommendations for feasible remedial action. The outcome of the meetings would be presented to and discussed by the full Cabinet and subsequently submitted to the Head of State and Parliament in the form of an annual progress report on the Programme of Action.

The meetings at the various administrative levels would be timed to precede the annual budget preparation process. It should be noted, however, that the process envisaged cannot be institutionalised overnight. It represents a goal towards which steady progress would need to be made during the programme period. Nevertheless, a first trial run would be made in 1993 in the expectation that an on-going process would be established by 1995-96.

IV. GENERATING DATA FOR SUCCESSFUL MONITORING

The effectiveness of the institutional framework and process proposed above would depend, to a significant extent, on the availability and timeliness of information on relevant monitoring indicators. To be useful, this information would also have to be disaggregated to reveal and track the evolution of gender and spatial disparities. A considerable investment would, therefore, be made to incorporate these issues in regular and periodic monitoring and evaluation activities. In specific terms, the measures proposed in the NPA to strengthen sectoral information systems would include, inter alia: an examination of the sensitivity of data collection, analysis and use to gender and spatial disparities; the strengthening of regular reporting systems; the launching of periodic surveys; and the maintenance of sustained interest and demand for the relevant information.

The monitoring indicators for the NPA would be classified into three distinct categories: input indicators such as annual budgetary allocations and actual expenditures, numbers of personnel trained by administrative level and type, the number and type of physical facilities constructed or rehabilitated and so forth; output indicators such as service coverages attained during the year (as a proportion of the target population) as well as further information on, for example, changing epidemiological patterns for which data are collected on a regular basis; and impact indicators such as mortality rates which reflect the cumulative medium- to long-term effects of programme activities as well as other factors such as changes in income as well as evolving conditions in the living environment.

The NPA has been prepared using, to the extent possible, existing sources of information, to develop a baseline for establishing the overall and sectoral objectives as well as for assessing progress. These sources include the Ghana Demographic and Health Survey/GDHS (1989), the Ghana Living Standards Survey/GLSS (1989), the Annual MCH/FP Reports of the Ministry of Health, studies and annual censuses conducted by the Ministry of Education and programme documents of the Ghana Water and Sewerage Corporation.

In those cases in which there is conflicting, unreliable or outdated information on indicators, surveys would be commissioned between 1992-94 to close the gap. Thus, a national survey on infant, child and maternal mortality is already on-going and should be completed by the end of 1992. A study on a similar scale, on child nutritional status, has the necessary funding and is expected to be undertaken in 1993. In addition, the Second Year Report of the GLSS, covering 1989-90, should be available by mid-1992. A second GDHS is also being planned for 1993. In addition, it is proposed that a coverage survey on access to water and sanitation facilities as well as surveys and special studies on children in especially difficult situations (CEDS) be commissioned in 1993. Finally, the Ghana Statistical Service (GSS) is scheduled to undertake a national population census in 1994 which would provide an opportunity for generating baseline data though there would be some time lag before preliminary results became available.

As for on-going monitoring of input and output indicators, the task would be performed by the responsible sectoral ministry/agency as part of its regular information gathering activities. As mentioned earlier, provision has been made in the NPA to address identified weaknesses in the latter area by building upon work already underway, for example, within the MOE.

Considerable emphasis has been placed on the integration of communities within the regular sectoral monitoring systems. There are two areas in which they would play a particularly prominent role. Firstly, communities would generate primary data on indicators monitorable at the grassroots level. In the case of inputs, this would include information on the number and scope of child-related initiatives and related resource mobilisation. With regard to outputs, data could be collected on the physical growth of children (through growth monitoring), vital events, immunisation coverage, morbidity patterns and school attendance. Secondly, communities would undertake their own assessment of the quality and effectiveness of independent and assisted

initiatives and services. Both types of information would be utilised at the community level as well as integrated into sectoral reporting systems. This objective would be achieved by expanding and improving the quality of inter-action between the field staff of line departments and communities. The data and analysis compiled as a result would be furnished as part of the periodic reports required from field personnel as well as separate reports prepared by supervisory staff. As a further measure, communities would be urged to use their representative to the District Assembly as a channel for voicing their concerns on project and other related issues and for ensuring accountability for service providers.

Monitoring at the grassroots level would be complemented through increased reliance on line departments in the districts for the generation and preliminary analysis of primary data on input and output indicators, using, in part, information collected by communities. This focus would be supportive of the progressive decentralisation of social services which is a cornerstone of Government policy and an important strategy within the NPA. Activities proposed in the Programme of Action would strengthen or assist in the establishment of key bodies such as the District Education Offices (DEOs), District Health Management Teams (DHMTs) and Rural Water Supply and Sanitation Units (RWS/SUs). The decentralisation of the regular reporting system would be supplemented by additional measures involving, for example, the establishment of sentinel sites in each region (see PHN Programme) and the use of rapid assessment procedure (RAP) studies.

With regard to the assessment of impact, the NPA proposes that a National Social Survey based on a consolidated version of the GDHS/GLSS be commissioned every five years (1996-97, 2001-2). This would not be an expensive activity since the capacity of the Statistical Service has already been strengthened for this purpose and nationally representative population samples would have been developed for on-going surveys.

The monitoring data generated from the system proposed above would serve as inputs into the annual meetings mentioned in section III. They would also provide the information necessary for a mid-term evaluation of the NPA in the last quarter of 1997. Furthermore, the impact of the data would be fully exploited through the publication of a biennial Report on the State of Ghanaian Children. The first issue would be published in 1994. An updated GOG/UNICEF Situation Analysis of Children and Women would also be published in 1995.

The proposed monitoring framework for the Programme of Action, as its relates to the nine major goals, is presented in Table 6.1.

Table 6.1
A Monitoring Framework for the National Programme of Action

MAJOR GOAL	INDICATOR	CURRENT STATUS	TARGETED STATUS IN 2002	SOURCE OF DATA	RESP. AGENCY
Reduction of Infant Deaths by 35%	Infant Mortality Rate (IMR)	77/1000 live births (1988)	50/1000 live births	* GDHS (1989) * National Mortality Study (1992) * National Social Survey (1997, 2002)?	GSS
Reduction of under Five Deaths by 35%	Under Five Mortality Rate (U5MR)	155/1000 Live births (1988)	100/1000 Live births	As above	As above
Reduction of Maternal Deaths by 33%	Maternal Mortality Rate (MMR)	5-10/1000 Live births	2.5-5/1000 Live births	* National Mortality Study (1992) * National Social Survey (1997,2002)?	GSS
Reduction of Severe Malnutrition Among Under Fives by 50%	Proportion of the Age Group Clinically Classifable as Suffering from Marasmus and Kwashiorkor	8% (1986)	4%	* National Nutrition Survey (1986) * GLSS (1992)? * National Nutrition Survey (1993) * National Social Survey (1997, 2002)?	GSS
Reduction of Moderate Malnutrition Among Under Fives by 50%	Proportion of the Age Group Below 80% of the US-NCHS Weight-for-Age Standard (Underweight)	58.5% (1986) 31.4% (1988)	29.3% 15.7%	As Above Alderman (1991)	As Above
	Proportion of the Age Group Below 90% of the Height-for-Age Standard (Stunting)	51.5% (1986) 19.6% (1988)	25.8% 9.8%	As Above	As Above
	Proportion of the Age Group Below 80% of the Weight-for-Height Standard (Wasting) or	40.3% (1986) 5.1% (1988)	20.2% 2.6%	As Above	As Above

Table 6.1
A Monitoring Framework for the National Programme of Action

MAJOR GOAL	INDICATOR	CURRENT STATUS	TARGETED STATUS IN 2002	SOURCE OF DATA	RESP. AGENCY
	Proportion of the Age Group which fall Two or More Standard Deviations Below the Median of the Reference Population for Weight-for-Age, Height-for-Age, Weight-for-Height	- 20.3% 31% and 7.9% (1988)	- 10.2% 15.5% and 4%	* Alderman (1991) * GLSS (1992)? * National Nutrition Survey (1993) * National Social Survey (1997, 2002)?	As Above
Universal Access to Basic Education	Proportion of Children in the Relevant Age Group (6-11 yrs) in Primary School	67% (1988-89)	98%	* GLSS (1989, 1992) * Annual Education Census	GSS MOE
	Proportion of Children in the Relevant Age Group (12-14 yrs) Enroled in Junior Secondary School	?	?	* Annual Education Census	MOE
Completion of Prim. School by at least 80% of Children in the Relevant Age Group (6-11 yrs)	Proportion of Children in the Relevant Age Group completing Primary School	40.2% (estimate for 1990)	80%	* Annual Education Census	MOE
Reduction of the Female Illiteracy Rate by 50%	Female Illiteracy Rate (15 yrs of Age and Above)	77%* (1988)	38.5%	* GLSS (1989, 1992) * National Social Survey (1997, 2002)?	GSS
Increase in the Coverage of Safe Water Supply to 90% of the Rural Population (by the year 2010)	Proportion of the population with Access to a Minimum of 20 Litres of Safe Drinking Water per Day from a Source Not more Than One Kilometre Away	?	?	* MWH(1991) * GWSC * GLSS (1989, 1992) * Coverage Survey (1993) * National Social Survey (1997,2002)?	GWSC GSS GWSC GSS

This figure refers to those 9 years of age and above

Table 6.1
A Monitoring Framework for the National Programme of Action

MAJOR GOAL	INDICATOR	CURRENT STATUS	TARGETED STATUS IN 2002	SOURCE OF DATA	RESP. AGENCY
Increase in the Coverage of Facilities for Sanitary Means of Excreta Disposal to 90% of the Rural Population (by the year 2010)	Proportion of the Population with Access to Sanitary Means of Exreta Disposal (Defined as Any System of Disposal Between Pit Latrines and Flush Toilets)	?	?	* MWH (1991) * GWSC * GLSS (1989, 1992) * Coverage Survey (1993)? * National Social Survey (1997,2002)?	 GWSC GSS GWSC GSS
Reduce the Proportion of Children in Especially Difficult Situations	Incidence of disability (the term will be defined more specifically)	NA	To be formulated	* National Survey (1993)? * National Social Survey (1997,2002)?	Universities GSS GSS
	Incidence of Teenage Pregnancy	NA	To be formulated	* National Survey (1993)?	MOH
	Proportion of Children on the Street (the term will be defined more specifically)	NA	To be formulated	* National Survey (1993)? * National Social Survey (1997,2002)?	GSS Universities
Widespread Acceptance and Observance of the Convention on the Rights of the Child	All Indicators Mentioned Above	See Above	See Above	See Above	See Above
	Level of Awareness/ Knowledge of the Convention Among the Population (to be defined more specifically)	NA	To be formulated	* KAPB Studies (1993, 1997, 2002)?	GNCC Universities
	Incorporation of Child Rights in the Constitution and Other Laws	Partial Incorporation into Laws	To be formulated	* GNCC (1990) * Studies (1993, 1997)?	As Above

NA – not available

Annex A

MEMBERSHIP OF THE MULTI-SECTORAL TASKFORCE (MSTF)

Dr. Charlotte Gardiner	- Ministry of Health (Chairperson of the MSTF)
Mrs. Esther Yaa Apewokin	- Ministry of Finance and Economic Planning (Vice-Chairperson of the MSTF)
Mrs. Amelia Djabanor	- Ghana National Commission on Children
Mrs. Regina Apotsi	- As Above
Mrs. Diana Ayettey	- Ministry of Finance and Economic Planning
Dr. K. O. A. Appiah	- National Development Planning Commission
Dr. Osei-Bonsu	- As Above
Dr. Evelyn Awittor	- As Above
Mrs. Theodora Donkor	- Ministry of Education
Mrs. Patience Adow	- As Above
Ms. Comfort Ashietey	- Ministry of Local Government
Mrs. Esther Kwawu	- Ministry of Agriculture
Ms. Ama Serwah	- Ministry of Mobilisation and Social Welfare
Mrs. Peace Ocansey-Colerangle	- Ghana Water and Sewerage Corporation
Ms. Atawa Akyea	- National Council on Women and Development
Mrs. Edith Hazel	- 31st December Women's Movement
Mr. Anthony Ekpedzor	- National Secretariat of the Committees for the Defence of the Revolution
Mr. Isaac Awuku	- Ghana Association of Private Voluntary Organisations for Development
Mr. Turhan Saleh	- United Nations Children's Fund

Annex B

THE FRAMEWORK FOR COSTING

I. General Principles

In designing the costing system, the following served as guidelines: input/output transparency, verifiability, flexibility and consistency, and managerial usefulness. They are discussed below.

(i) Input/Output Transparency

For every activity/programme summary, the required inputs - categorised under headings such as CIVIL WORKS, EQUIPMENT, SUPPLIES, TECHNICAL ASSISTANCE, VEHICLES and OTHERS - are specified in terms of time, quantities and values, where values are unit prices multiplied by quantity. Activity analysis ensures that the specified inputs will be adequate for the attainment of expected outputs. For example, if one of the outputs from an activity is the completion of studies, activity analysis would proceed as follows: how will the study be conducted? what will be the nature/number of personnel required? what will be the duration of the assignment? and what logistics support would be needed? Answers based on experience from similar studies and insights from operational staff responsible for the preparation of the studies' terms of reference (TOR) would then assist in estimating and sequencing the inputs required to obtain the desired outputs.

(ii) Verifiability

Using the same input quantities, sequencing and unit prices, an independent person should be able, on a step-wise basis and without difficulty, to either confirm or reject the total value of resource requirements.

(iii) Flexibility and Consistency

The costing formats designed should aid in sensitivity analysis: the impact of, for example, input changes and unit cost variations on total values could be computed without much effort.

With regard to consistency in the use of bench-marks - unit costs, vehicle operating costs in relation to vehicle cost, duration of similar training programmes and so forth - both within and across activities/programmes, are made transparent, except where factors like location and intensity of input use make the consistency rule inappropriate.

(iv) Managerial Usefulness

The costing system is based on a plan, as expressed in programme activities. For the system to be useful to managers, it should have the features of a budget, that is, a plan expressed in time and money. The system viewed as a budget should help managers/implementers to verify the following questions, amongst others:

a. the total cost of and financing required by an activity/programme, by year and overall duration;

b. the inter-temporal use of inputs, thus, helping to prepare procurement plans; and

c. the dichotomy between capital and recurrent costs by year/overall duration and their impact on financing strategies.

II. Factors Likely to Affect Costings

Changes in the exchange rate, the rate of inflation, salary structures and quantities are likely to affect the costings. These factors are discussed below on a "ceteris paribus" basis (that is, all other things being equal).

(i) The Exchange Rate

Unit costs of inputs were first computed in local currency (cedi) at prevailing 1992 prices and then converted into dollars at an exchange rate of $1 = C400. Hence, any variation in the exchange rate will lead to a change in the dollar values in the cost tables.

(ii) The Rate of Inflation

An important consideration with the rate of inflation is the choice of the price series to be utilised since the Consumer Price Index (CPI) would not accurately reflect changes in the prices of inputs "consumed" by development programmes. Appropriate indices for sectors or sub-sectors would need to be constructed to yield reliable estimates of the likely impact of inflation on programme costs. Changes in the inflation rate (whether general or disaggregated) could be partially captured by the exchange rate but there would still be non-traded resources whose price levels would not be predicted with accuracy by the exchange rate. Examples include accommodation and board costs of training programmes in rural areas and localised labour input into civil works.

(iii) Salary Structures

Since compensation for employees constitutes a large proportion of recurrent costs, the latter will be sensitive to changes in governmental salary structures. For example, the resource requirements for the PHN Programme were estimated before the nurse's strike, the resolution of which might alter the magnitude of incremental recurrent costs during 1993-97.

(iv) Quantities

The volume of resource use planned at the inception of the programme, if changed, will necessitate modifications in the corresponding monetary values. Quantity changes may result from alterations in the magnitude and/or duration of an activity.

III. Sources of Unit Costs

(i) Imported Items

The unit costs of imported items such as vehicles, typewriters, computers, photocopiers and other equipment were obtained from local suppliers. Where variations in prices existed due to differences in product specification, the prices for the particular specification which programme implementers had in mind was used.

(ii) Training Activities

Actual costs of training programmes conducted, unit costs used in previous programme/project documents and the unit cost of training programmes organised by the private sector were rationalised to arrive at the unit cost for a particular training programme.

(iii) Civil Works

Cost figures based on existing blueprints for classrooms, hand-dug wells and so on were utilised after adjustments, where necessary.

IV. Next Steps

The next steps required to further refine the cost estimates would necessitate:

a. a breakdown of costs into foreign and local components;

b. a review and re-costing of some of the blueprints under civil works;

c. with TORs for technical assistance completed, a reconsideration of the costings for technical assistance (TA);

d. further scrutiny of the recurrent cost implications of the NPA; and

e. additional investigations into low-cost approaches, using options analysis, with a focus on technology choice, rationalisation of programmes and delivery structures, improved social communication, greater reliance on the private sector/NGOs and intensified community mobilisation.

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