MASTER PLAN OF OPERATIONS

1991-1995

GOVERNMENT OF GHANA/UNICEF

GOVERNMENT OF GHANA/UNICEF

1991-1995

MASTER PLAN OF OPERATIONS

5 August, 1991

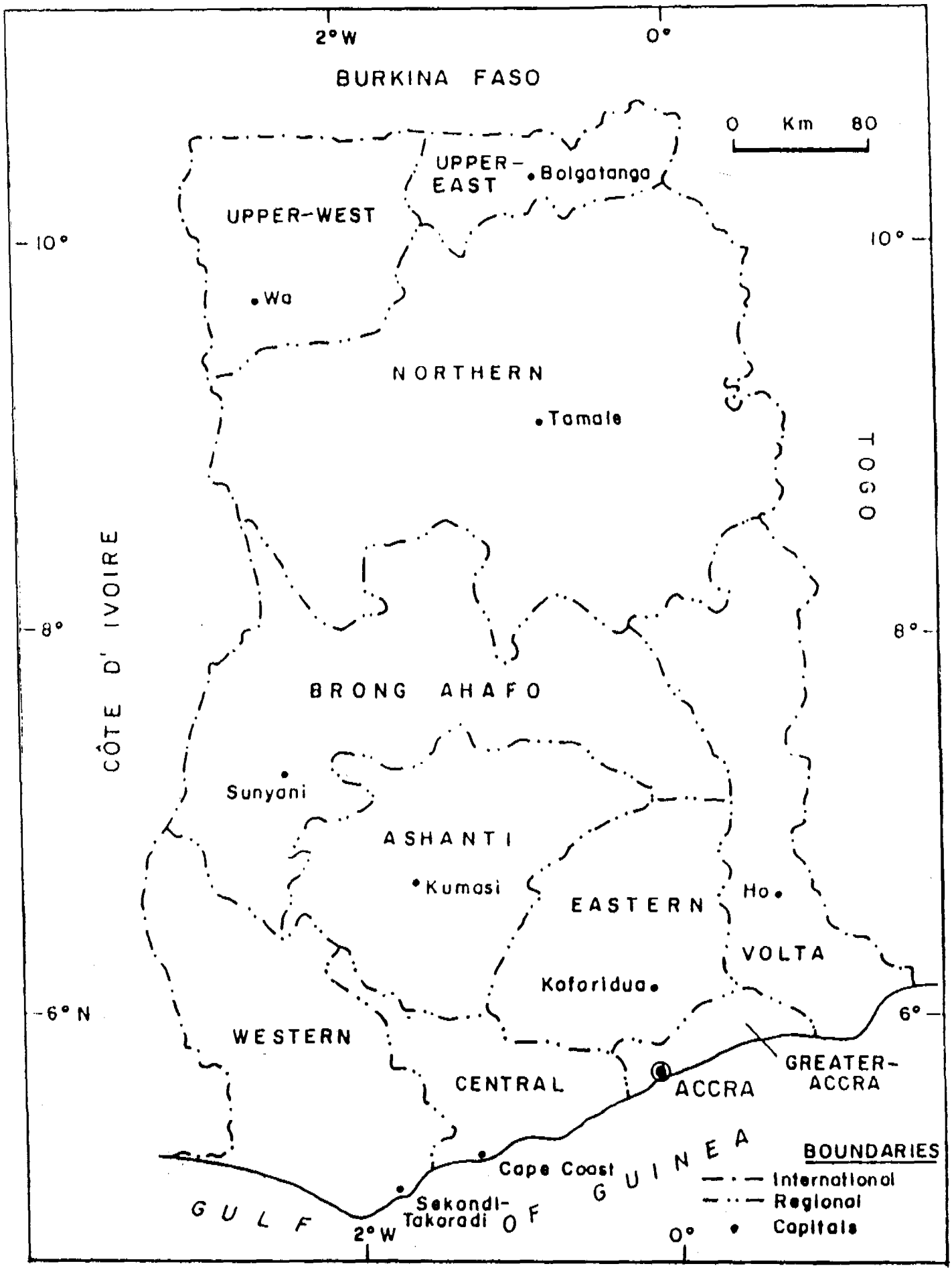
CONTENTS

ABBREVIATIONS

ADB	African Development Bank
AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Illnesses
BCG	Tuberculosis Vaccine
CDD	Control of Diarrhoeal Diseases
CDR	Committee for the Defence of the Revolution
CIDA	Canadian International Development Agency
CPHA	Canadian Public Health Association
CSD	Child Survival and Development
DCD	Department of Community Development (MLG)
DHMT	District Health Management Team
DPT	Diphtheria/Pertussis/Tetanus Vaccine
DSMCCSD	District Social Mobilisation Committee on CSD
ECD	Early Childhood Development
EPI	Expanded Programme on Immunisation
ERP	Economic Recovery Programme
FAO	Food and Agriculture Organisation
GLSS	Ghana Living Standards Survey
GDHS	Ghana Demographic and Health Survey
GDP	Gross Domestic Product
GNCC	Ghana National Commission on Children
GNP	Gross National Product
GWSC	Ghana Water and Sewerage Corporation
IDD	Iodine Deficiency Disorder
IMR	Infant Mortality Rate
JICA	Japanese International Co-operation Agency
KAP	Knowledge, Attitudes and Practices
KVIP	Kumasi Ventilated Improved Pit latrine
MCH	Maternal and Child Health Care
MFEP	Ministry of Finance and Economic Planning
MIST	Ministry of Industry, Science and Technology
MLG	Ministry of Local Government
MMR	Maternal Mortality Rate
MOA	Ministry of Agriculture
MOE	Ministry of Education
MOH	Ministry of Health
MOI	Ministry of Information
MTADP	Medium Term Agricultural Development Programme
NCWD	National Council on Women in Development
NDPC	National Development Planning Commission
NGO	Non-Governmental Organisation
NSMCCSD	National Social Mobilisation Committee on CSD
OAU	Organisation of African Unity
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PAMSCAD	Programme of Actions to Mitigate the Social Costs of Adjustment
PHC	Primary Health Care
PIP	Public Investment Programme

PNDC	Provisional National Defense Council
RCC	Regional Co-ordinating Council
RSMCCSD	Regional Social Mobilisation Committee on CSD
RWD	Rural Water Department (of GWSC)
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
U5MR	Under 5 Mortality Rate (children 0-4 years)
UCI	Universal Child Immunisation
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Voluntary Fund for Women
USAID	United States Agency for International Development
WCARO	UNICEF West and Central Africa Regional Office
WB	World Bank
WFP	World Food Programme
WFSPP	Weaning Food Storage and Processing Project
WHO	World Health Organisation

MAP OF GHANA


2°W
0°
BURKINA FASO
0 Km 80
UPPER-EAST
Bolgatanga
UPPER-WEST
10°
Wa
NORTHERN
Tamale
TOGO
CÔTE D' IVOIRE
8°
BRONG AHAFO
Sunyani
ASHANTI
Kumasi
EASTERN
Ho
VOLTA
Koforidua
6° N
6°
WESTERN
CENTRAL
ACCRA
GREATER-ACCRA
Cape Coast
Sekondi-Takoradi
GULF OF GUINEA
BOUNDARIES
International
Regional
Capitals

SECTION I:

MASTER PLAN OF OPERATIONS

FOR THE 1991-1995

UNICEF/GOVERNMENT OF GHANA

PROGRAMME OF CO-OPERATION

A. AGREEMENT

Preamble

The Government of Ghana, hereinafter referred to as the Government and the United Nations Children's Fund, hereinafter referred to as UNICEF, desiring to enter into a Programme of Co-operation for the period 1991-1995 to improve the survival and development of the children and women of Ghana

HAVE AGREED TO THE FOLLOWING:

ARTICLE I: Basis of Relationship

The Basic Agreement concluded between the Government and UNICEF on 12 August, 1958 provides the basis of the relationship until such time as it may be amended by joint agreement of the two parties. The 1991-1995 Programme of Co-operation described herein is to be interpreted and implemented in accordance with the Basic Agreement and supercedes all previous Programmes of Co-operation. The Programmes, Projects and Activities described in this Master Plan of Operations have been jointly agreed by the Government and UNICEF, and each has specified the nature of its commitments herein.

ARTICLE II: Goals and Objectives

The 1991-1995 Programme of Co-operation shall have the underlying goal of improving the welfare of children and women in Ghana through priority interventions designed to enhance their chances of surviving and leading healthy and productive lives as agents of change and social and economic development.

The main objectives of the 1991-1995 Programme of Co-operation are the:

a. Reduction of the Under Five Mortality Rate (U5MR) by 16 percent to approximately 134 per thousand live births in 1995;

b. Reduction of the maternal mortality rate by 25 percent;

c. Improved access to, and achievement of, basic education for all Ghanaian children, and improved literacy for women;

d. Enhanced capacity for planning and implementing social development initiatives, particularly at the district and community levels, and especially involving women; and

e. Enhanced health knowledge, based on "Facts for Life", among parents, especially mothers.

ARTICLE III: PROGRAMME STRATEGY

The principal strategies for pursuing the above goals and objectives within the 1991-1995 Programme of Co-operation will be as follows:

a. Focus on the Primary Health Care approach enunciated at the Alma Ata Conference in 1978, with specific emphasis on controlling child-killing diseases through Universal Child Immunisation and use of Oral Rehydration Therapy;

b. Adherence to the Bamako Initiative principles of community financing to help ensure the sustainability of Primary Health Care;

c. Recognition of the role of women as essential agents of change and key initiators, planners, and implementers of development activities, in addition to benefiting from those activities;

d. Emphasis on the importance of adequate maternal and child nutrition as a means of ensuring survival and development; and

e. Use of mobilisation and advocacy to build alliances and put essential health knowledge into the hands of policy-makers and beneficiaries.

ARTICLE IV: Programme Components

The 1991-1995 *Programme of Co-operation will consist of the following* programmes and projects:

a. Health and Nutrition Programme:
   i. Expanded Programme on Immunisation and Oral Rehydration Therapy;
   ii. District Primary Health Care Development;
   iii. National Food and Nutrition Policy Development; and
   iv. Control of Iodine Deficiency Disorders.
   v. Support to the Safe Motherhood Programme;

b. Water and Sanitation Programme:
   i. Rural Water Supply; and
   ii. Environmental and Domestic Sanitation.

c. Basic Learning Needs Programme:
   i. Life Skills in Primary School (CSD);
   ii. Non-Formal Education; and
   iii. Early Childhood Development.

d. Social Mobilisation:
   i. Advocacy and Mobilisation of Allies; and
   ii. Media Development;

e. Planning, Monitoring and Evaluation:
   i. Research and Analysis;
   ii. Programme Monitoring; and
   iii. Evaluation.

ARTICLE V: Assignment of Responsibility

The Government and UNICEF share responsibility for the planning, monitoring and evaluation of the 1991-1995 Programme of Co-operation, while the Government or its designated agencies have primary responsibility for implementation. The Government and UNICEF will collaborate with specific identifiable groups or Non-Governmental Organizations (NGOs) to implement certain project activities.

Within the Government, the Ministry of Finance and Economic Planning (MFEP) shall be responsible for the overall co-ordination and implementation of Government inputs into the Programme of Co-operation. The MFEP shall also ensure adequate co-ordination of programme inputs from other donors to permit activities within the Programme of Co-operation to promote complementarity and maximum impact.

The Ministries of Health, Education, Mobilisation and Social Welfare, Agriculture and Local Government, as well as the Ghana Water and Sewerage Corporation, the Ghana National Commission on Children and the National Council on Women and Development, the Ghana Statistical Service, other concerned Government agencies, and any NGOs involved in implementation, shall designate a Project Officer for each project outlined in the Plan of Operations, to oversee national level activities. In addition, each Regional Administration shall designate a Focal Person to oversee the social development sector, including the implementation of activities in that region supported by UNICEF and other donors, and to ensure adequate co-ordination of donor inputs.

The Government (or NGO) Project Officers, and the Social Sector Development Focal Persons, shall be responsible for the planning, budgeting and release of financial and material inputs for activities, up to the annual amounts agreed in the Plan of Operations and indicated in each annual Project Plan of Action, under the overall co-ordination of the MFEP.

UNICEF will provide material, financial and technical assistance to each programme and project outlined in the Plan of Operations and detailed in annual

Project Plans of Action, to the value of the sum of the UNICEF General Resources, plus any Supplementary Funds received as of any given moment.

UNICEF shall be responsible for preparing such supporting documentation as may be necessary to accompany the submission of Supplementary Funding proposals (developed jointly with the Government) to donor governments, agencies or NGOs to raise Supplementary Funds for activities outlined in the Plan of Operations.

All UNICEF assistance will be provided in conformity with the policies and directives of the UNICEF Executive Board. UNICEF will provide the Government with all necessary information relating to these policies and directives and any changes in same as may take place within the duration of this Agreement.

ARTICLE VI: Commitments of the Government

The 1991-1995 Programme of Co-operation shall be implemented in conformity with Ghanaian laws and policies. The Government, through the Ministry of Finance and Economic Planning, is responsible for providing UNICEF with information regarding these laws and policies and any changes in said laws and policies or in the structure of the Government or assignment of responsibilities within the Government which may affect the implementation of the Programme of Co-operation.

The Government shall provide all premises, facilities, personnel, materials, supplies and financial support necessary for the Programme of Co-operation except as provided by UNICEF, other donor agencies, NGOs or communities. The value of Government support to the Programme of Co-operation shall be approximately the equivalent of US$ 97,867,790 over the duration of this Agreement. Government support to the Programme of Co-operation is summarised as follows:

GOVERNMENT BUDGET SUMMARY BY PROGRAMME

Health and Nutrition: US$ 69,450,000
Water and Sanitation: US$ 1,090,790
Basic Learning Needs: US$ 24,027,000
Social Mobilisation: US$ 3,300,000
Planning, Monitoring and Evaluation: US$ 1,000,000

ARTICLE VII: Commitments of UNICEF

UNICEF, from its General Resources, shall support the 1991-1995 Programme of Co-operation by providing equipment, supplies, transport, technical

assistance, training support and cash assistance to a value not exceeding US$ 11,500,000 between 1 January, 1991 and 31 December, 1995.

UNICEF will also make every effort to mobilise additional resources, in the form of Supplementary Funds, from other UNICEF and non-UNICEF sources to support the programmes, projects and activities outlined in the Programme of Co-operation. The Supplementary Funds required to fully implement this Programme of Co-operation amount to US$ 8,500,000 over the five year duration of this Agreement. UNICEF will provide this amount subject to donor response and the availability of funds. The release all UNICEF funds shall be contingent upon the Government's compliance with its commitments for each programme and project outlined in this Programme of Co-operation. UNICEF assistance to the Programme of Co-operation is summarised as follows:

UNICEF BUDGET SUMMARY BY PROGRAMME

(THOUSANDS OF US DOLLARS)

PROGRAMMES	1991	1992	1993	1994	1995	1991/95
HEALTH AND NUTRITION	1970	1602	2145	2094	1782	9593
BASIC LEARNING NEEDS	387	651	731	824	795	3388
WATER AND SANITATION	517	758	786	798	652	3511
SOCIAL MOBILISATION	260	325	270	225	225	1305
PLANNING, MONITORING & EVALUATION	257	91	157	242	107	854
PROGRAMME SUPPORT	480	407	348	365	384	1984
TOTAL COUNTRY PROGRAMME	3871	3834	4437	4548	3945	20635
General Resources	2325	2325	2325	2325	2325	11625
Funded Sup. funding	510	0	0	0	0	510
Unfunded Sup funding	1036	1509	2112	2223	1620	8500
GRAND TOTAL	3871	3834	4437	4548	3945	20635

ARTICLE VIII: Role of Other Donor Agencies

A large number of other international donor agencies will be supporting activities having a direct bearing on many of the programmes and projects to be supported by UNICEF during 1991-1995. Collaboration will be particularly strong in the areas of EPI (Rotary International, USAID, WHO, World Bank and World Vision); ORT (Jaycees International and USAID); Safe Motherhood (UNFPA, USAID and World Bank); Essential Drugs (EEC and World Bank); strengthening of health infrastructure and DHMTs (UNDP and WHO); community nutrition (WFP, World Bank and World Vision); nutrition policy development (FAO and WFP); IDD

(International Development Research Centre and WHO); water and sanitation (CIDA, Global 2000, JICA and UNDP); education (UK-ODA, UNFPA, USAID, World Bank); women in development (CIDA, UNFPA, UNDP and World Bank); social mobilisation on AIDS (USAID and WHO); and planning and statistics (CIDA, UNDP and UNFPA).

ARTICLE IX: Accounting, Monitoring and Evaluation

All supplies and equipment provided by UNICEF under the 1991-1995 Programme of Co-operation shall be transferred to the Government (or to the appropriate NGO) upon their arrival in the country. Transfer shall be accomplished upon delivery to UNICEF of a signed receipt or, in the case of vehicles, a signed Loan Agreement. If any supplies or equipment thus transferred are not used for the purposes for which they were provided, as outlined in the Plan of Operations, then UNICEF may require their return and the Government will facilitate such return.

Government shall be responsible for the rapid clearance from Customs of all supplies and equipment provided by UNICEF and for their receipt, internal transport, and adequate storage and shall provide to UNICEF a proper accounting as required by UNICEF's standards and practices. Supplies and equipment provided by UNICEF shall be stored and accounted for separately from all other supplies and equipment provided from other sources.

Vehicles supplied by UNICEF shall be used exclusively according to the rules and procedures contained in the Loan Agreement and Schedule of Assignment for each such vehicle. Records relating to the use of each vehicle shall be made available to UNICEF staff upon request.

The payment of, and accounting for, cash assistance provided by UNICEF under this Programme of Co-operation shall be carried out in accordance with UNICEF accounting procedures. Accounting for cash assistance provided by UNICEF shall be done separately from all other funds used in the activities outlined in this Programme of Co-operation. For all funds transferred from UNICEF to the Government in advance of actual expenditures, the Government agency will provide to UNICEF original receipts and/or purchase orders, together with any other documentation as may be required by UNICEF's accounting system, within three months of receiving such funds. Together with the receipts, purchase orders and other documentation, the recipient will return to UNICEF any funds transferred in advance of actual expenditures which remain unspent after three months following their transfer.

The Government, through the Ministry of Finance and Economic Planning, agrees to provide to UNICEF upon request any such information regarding supplies, equipment or cash it has received as shall be required by UNICEF to comply with its own or with United Nations audit procedures.

The Government and UNICEF agree to participate together in Annual Planning and Review Meetings and in a Mid-Term Review of the 1991-1995 Programme of Co-operation during the course of the third year of the Programme of Co-operation (1993). Both parties also agree to participate in any other evaluations related to the Programme of Co-operation or its constituent programmes, projects and activities as either of the two parties may require.

ARTICLE X: Final Provisions

Upon signature of this Agreement by the Government and UNICEF, the Plan of Operations contained in this Programme of Co-operation shall become immediately effective and shall remain in force until 31 December, 1995.

The Plan of Operations may be modified by mutual consent of the two parties concerned provided such modifications are formalised by amendment to this Agreement or by an exchange of letters.

Upon completion of any programme, project or activity outlined in the Plan of Operations, any supplies, equipment or vehicles remaining shall be disposed of by mutual agreement between the Government and UNICEF, with due consideration to the sustainability of said activity. Any supplies, equipment or vehicles to which UNICEF has retained title will be disposed of by UNICEF in accordance with established UNICEF procedures.

In witness whereof the parties hereto have signed this Agreement and Programme of Co-operation this **6** day of **September** 1991 at Accra, Ghana.

DR. KWESI BOTCHWEY

Signed on behalf of the Government of Ghana by the PNDC Secretary for Finance and Economic Planning

PNDC SECRETARY
MINISTRY OF FINANCE &
ECONOMIC PLANNING

MR. S.M. SHOMARI

Signed on behalf of the United Nations Children's Fund (UNICEF) by the Representative to Ghana

UNICEF

B. CHILDREN AND WOMEN IN GHANA IN 1989-1990:

Summary of the Situation Analysis

THE CHANGING NATIONAL CONTEXT

1. The Ghanaian economy is experiencing serious constraints due to a combination of internal and external factors including: high inflation, low private savings and investments, sharp reversals in the terms of trade, high levels of debt servicing and declining net resource transfers. Nonetheless, despite past and present difficulties, Ghana has made impressive progress since the adoption of the Economic Recovery Programme (ERP) in 1983 as indicated by an average annual growth rate in real GDP of six percent during the period 1984-1989. The country has, therefore, emerged from crisis to reach the threshold of opportunities to pursue human development and achieve a significant improvement in the health, nutritional and educational status of her people.

2. Nonetheless, the structural adjustment measures which are gradually improving the overall strength of the Ghanaian economy have had a negative impact on some sectors of society. In recognition of this situation, the Government launched the Programme of Actions to Mitigate the Social Costs of Adjustment (PAMSCAD) as a means of assisting vulnerable groups -- small farmers, rural and urban un- and under-employed and "redeployed" workers -- which have suffered from the past decade of economic decline as well as the adverse short-term effects of adjustment. The programme is designed to provide a temporary "bridge" until the benefits of economic recovery become more widely available to the entire population in the medium and long term. Implementation of PAMSCAD began in 1988 and is still on-going.

3. The Government has firmly committed itself to a policy of decentralising responsibility for development and provision of social services. In this regard, District Assemblies were established in all 110 districts by late 1989 and, in most, social sector sub-committees have been constituted. As an integral part of this process, Regional Co-ordinating Councils (RCCs) have also been created in each of the ten regions. One of their principal tasks will be the co-ordination, monitoring and evaluation of the functioning of District Assemblies.

4. In addition, the National Civil Service is being restructured to more effectively meet local needs. A new National Development Planning Commission (NDPC) is in the process of being established with responsibility for the formulation of national development strategies and plans, their implementation through relevant policies and programmes, and the monitoring and evaluation of outcomes. Regional and District Planning Officers help ensure implementation of national development strategies at the local level. The Ministry of Finance and Economic Planning, which formerly was in charge of all development planning, will continue to play a crucial role through its supervision of the Ghana Statistical Service which generates the

essential data used in development planning. Pending the complete operationalisation of the NDPC, supervision of the Regional Planning Officers remains with MFEP, and supervision of the District Planning Officers is the responsibility of the Ministry of Local Government.

5. The Government has given increasing priority to social sector programmes, as demonstrated by: a) increased real per capita expenditures on health and education; b) the implementation of far-reaching educational reforms; c) the establishment of a National Social Mobilisation Committee for Child Survival and Development; d) early ratification of the Convention on the Rights of the Child; and e) support for the OAU Declaration on the Decade of the African Child.

THE SOCIO-ECONOMIC SITUATION

Demographic Factors

6. The population of Ghana is currently estimated at some 14.6 million people (1989). Based on the 1984 National Census, the Government Statistical Service officially estimates a national population growth rate of 2.6 percent per annum, with the rate reaching as high as 4.5 percent per annum in some urban areas. However, the United Nations Division for Population Studies estimates a national growth rate of 3.4 percent per annum while the World Bank puts the current figure at 3.0 percent per annum. Based on these estimates, the infant (under one year of age) population of the country is between 420,000 and 586,000, a variation which casts some uncertainty on many key indicators.

7. It is estimated that 30 percent of the population lives in urban centres and that, of the 70 percent of the population living in rural areas, 66 percent live in communities of under 500 inhabitants. In all, the Government estimates that there are between 44,000 and 48,000 communities in the country scattered among 110 districts which are, in turn, grouped into ten regions.

Trends in Income and its Distribution

8. Although real per capita GDP increased at an average annual rate of 3.2 percent between 1984 and 1989, problems still exist in translating these gains into substantial growth in real household incomes to satisfy basic needs for food, shelter, health care, education and water and sanitation. One indicator of this situation is the index of the real minimum wage (1970=100) which increased steadily from the trough in 1983 until 1986, but then declined continuously until 1988. Indeed, the real minimum wage in 1988 retained only about 30 percent of its value in 1970.

Distribution of Income

9. Data from the 1989 Ghana Living Standards Survey (GLSS) show that there is not a wide disparity in income between the wealthiest and poorest 20 percent of the population. However, the GLSS does reveal marked inequalities by type of productive activity, rural or urban residence and regional location. Thus, farmers are the worst-off group, with cocoa farmers doing somewhat better than food producers; nearly two-thirds of the poorest 30 percent of the population are found in rural communities with less than 1,500 inhabitants; and about 60 percent of the tenth of the population with the lowest incomes are located in Northern Ghana with the other 40 percent split evenly between the coastal and forest zones.

Extent of Poverty

10. Although there is no official poverty line in Ghana, some independent studies indicate that there has been an increase in the absolute number of Ghanaians living in poverty. A study carried out by the International Fund for Agricultural Development (IFAD) in 1988 determined a poverty line for Ghana and estimated that, whereas 1.95 million smallholders were below the benchmark in 1970, the number had almost doubled to 3.8 million in 1986. Producers of products other than cocoa were particularly hard hit.

11. From the above data, it is evident that poverty in Ghana is still a significant and perhaps increasing problem. Poverty is also principally a rural phenomenon especially prevalent among those who are outside the cash or market economy. This situation is unlikely to improve without major efforts in the area of rural development embracing strategies and programmes for production, employment and the development of economic and social infrastructure and services.

Food Security

12. At the national level, Ghana is still not in a position to satisfy its cereal requirements domestically and must, therefore, rely on commercial imports as well as food aid to close its food deficit. In addition to this problem, the distribution and marketing of food crops is still stymied by a number of problems, such that imbalances in demand and supply between regions and communities are not adequately overcome.

13. The difficulties in ensuring food security at the household level are even greater. In rural areas, most farmers are smallholder subsistence food producers with meager income-generating opportunities due to a combination of low productivity, lack of off-farm employment and vulnerability to natural calamities, among other things. In urban areas, a large proportion of the population is engaged in the informal sector which is characterised by low productivity, unstable employment and modest incomes.

14. Food security also varies sharply by season, being especially problematic in the period prior to the harvest (April to August) called the "hungry" or "lean" season. The problem is particularly acute in the northern half of the country (the Northern, Upper East and Upper West Regions).

THE ENVIRONMENT

Housing

15. The housing stock has hardly increased even while population growth continues. Meanwhile, the growth of slums in and around major urban areas has led to poor quality of shelters and inadequate environmental hygiene. In rural areas, houses are generally poorly constructed and maintained meaning that a significant proportion of the population lives in an unhygienic environment.

Water and Sanitation

16. Approximately 51 percent of the total population does not have access to potable water. Only 15 percent of people living in communities of fewer than 500 inhabitants have access to clean drinking water, while some 70 percent of those living in communities of between 500 and 5,000 and 93 percent of those living in communities of more than 5,000 inhabitants (urban areas) enjoy such access.

17. Regionally, the most poorly served areas are the Northern, Upper East and Upper West and Volta Regions (27 percent, 39 percent and 45 percent, respectively). These low figures compare with a coverage of 91 percent in the Greater Accra Region.

18. The sanitation situation is also poor as only 50 percent of the urban and 15 percent of the rural population have adequate sanitation facilities, yielding a national coverage of 27 percent.

19. As with other quality of life indicators, the most disadvantaged Regions are the Northern, Upper East and Upper West -- between seven and eight out of ten people in these areas use the bush or open space for excreta disposal. The poor state of sanitation reinforces the effects of diseases caused by a poor environment and polluted water.

THE SITUATION OF CHILDREN

Infant and Child Mortality and Morbidity

20. The infant mortality rate (IMR) in Ghana is estimated at 77 per thousand live births for the period 1983-1987 (Ghana Demographic and Health Survey, GDHS,

1989). While this rate remains unacceptably high, it nonetheless indicates a significant reduction from the estimate of 90 per 1000 live births in 1986.

21. The mortality rate for children one to four years of age was estimated at 84 per 1000 live births for the period 1983-1987, indicating a deterioration from the rate of 72 per 1000 live births during the period 1978-1982.

22. The combined mortality rate for all children under five (U5MR) is estimated at 155 per thousand live births for the period 1983-1987 .

23. There are stark regional variations in infant and child mortality, with the Central Region (U5MR = 208 per thousand live births) and all the northern sector (the Northern, Upper East and Upper West Regions) being the worst affected (average U5MR = 222 per thousand live births). By contrast, the Greater Accra Region, which is relatively better-off economically, has an U5MR of 103.8 per thousand live births.

24. More than one third of deaths among children under five are caused by preventable and infectious diseases including malaria, measles, diarrhoeal diseases and acute respiratory infections. Approximately one out of every ten children dies from causes related to malnutrition and an almost equal number from low birth weight. These factors therefore account for almost 60 percent of all deaths among children under five years of age.

25. These same diseases are also the main causes of morbidity in children under five. Malaria stands out, contributing to almost 45 percent of all outpatient consultations, followed by acute respiratory infection (10 percent) and severe diarrhoea (seven percent).

Patterns of Malnutrition Among Children

26. The National Nutrition Survey (1986), using the US-NCHS standard, found that malnutrition is very common among children 0-60 months of age, with approximately 40 percent wasted (below 80 percent of the weight-for-height standard) and 51 percent stunted (below 90 percent of the height-for-age standard). Wasting is an especially serious problem in the Northern and Upper Regions, while the more chronic problem of stunting prevails to a greater extent in Western and Ashanti Regions. The combined effects are most serious in the Northern and Upper Regions. Moreover, seasonal variations in food availability

[1] The figure for the U5MR stated in the GDHS (1989) is problematic since it is less than the sum of the infant and 1-4 mortality rates found in the same study. Nonetheless, as this is the official Government figure, it is used throughout this Master Plan of Operations.

have an impact on nutritional status throughout the country and are, again, especially severe in the North.

27. Micro-nutrient deficiencies constitute another major nutritional problem in Ghana. Although precise figures are not available, Vitamin A and iodine deficiencies are known to be common in the Northern, Upper East and Upper West Regions. Studies conducted by the Noguchi Memorial Institute in the coastal savannah indicate that the problem may be more widespread.

Education

28. Approximately ten percent of the eligible age group (under six years of age) were enrolled in public or private pre-schools in 1987-1988, the last year for which data are available. Of this group, 52 percent were female. Most of the available facilities are in urban areas, in poor physical condition and mostly staffed by unqualified teachers.

29. Approximately one third of children in the relevant age group (6-11 years of age) are not attending primary school. Of those who do attend primary school, 27.1 percent of boys and 36.1 percent of girls drop out before finishing the basic primary cycle (up to sixth grade). Children leave school primarily for economic reasons such as inability to pay fees and provide for food and supplies. The same root cause, poverty, also leads to pressure on children to work rather than study in order to supplement household incomes.

30. The GLSS (1989) reveals that only 11.1 percent of children 9-14 years of age are literate. This low figure does not differ significantly by gender: 11.8 percent of boys and 10.4 percent of girls in this age group are literate. Taken in conjunction with substantial non-attendance in school and high drop-out rates, this situation suggests that the educational status of future generations may be at risk.

31. The literacy rate of the total population 9 years and over is estimated at 32.5 percent. Nonetheless, significant differences are observed for men and women: whereas the literacy rate of males is 42 percent, that of females is only 23 percent. Gender disparities in education are relatively narrow at a younger age but increase progressively with age, as can be seen from the following data:

Age Group	Literacy Rate		
	Female	Male	National
9-14	10.4%	11.8%	11.1%
15-24	38.5%	59.4%	49.1%
25-34	37.8%	64.2%	49.4%
35-44	23.3%	58.1%	39.8%
45-54	10.0%	40.2%	23.8%
55+	3.4%	20.4%	11.3%

The Status of Child Rights

32. Ghana has a number of legislative instruments which protect children from economic exploitation and promoting their development. While these legal provisions contain elements which are consistent with the Convention on the Rights of the Child, there is still considerable scope for updating and revising them.

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

a. 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, custom in Ghanaian society still works to the disadvantage of female children, the handicapped and those from particular areas, practices which are only partially addressed in legislation.

b. Unlike the Convention on the Rights of the Child (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.

c. In accordance with Article 15 of the Convention on the Rights of the Child, 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.

d. The sole law related to child stealing refers only to children under twelve years of age, a feature that requires amendment.

e. The rights of disabled children also require further attention, not least in terms of the facilities available for their education and recreation, which at present are very few in number.

f. Although not treated as a legal right, Government policy on Primary Health Care (PHC) is intended to improve access to health services for a large number of children.

34. While the preceding points have mainly highlighted some of the weaknesses in laws as they relate to children's rights, a phenomenon by no means unique to Ghana, it is clear that with the ratification of the United Nations Convention on the

Rights of the Child, the country has taken a significant step towards promoting the rights of children to survival, protection and development.

THE SITUATION OF WOMEN

Mortality and Morbidity

35. The currently accepted figure for the Maternal Mortality Rate (MMR), five to ten per 1000 live births, remains unacceptably high[2].

36. Hospital data (Antwi et al, 1989) indicate that the immediate causes of maternal death can be divided into two groups: direct causes (haemorrhage, infection, hypertensive disease of pregnancy and ruptured uterus) and indirect causes (sickle cell disease, anaemia and other cardiovascular and respiratory problems, among others). It is estimated that four out of every ten maternal deaths are due to preventable causes.

37. The major causes of morbidity among women are pregnancy-related conditions (haemorrhage, toxaemia) and infections of pregnancy as well as other conditions such as malaria, infective hepatitis and Guinea worm.

Malnutrition

38. Malnutrition among women, especially pregnant and lactating mothers, is a significant problem. Anaemia among pregnant women is high: 69 percent of women tested at pre-natal clinics in 1987 were found to be anaemic by WHO standards.

39. A survey conducted In 1989 found that 36 percent of women were classifiable as severely under-weight during the "lean season", compared with 19 percent during the rest of the year. This indicates a significant gender disparity as the comparative rates for men were 23 percent and three percent, respectively. Given that few of the malnourished women achieve acceptable weights even after the harvest, there are serious implications for their own health as well as for that of their foetuses and future children.

Fertility

40. The Total Fertility Rate (TFR) has decreased slightly from 6.71 in 1979-1980 to 6.4 in 1988. A high TFR implies short birth intervals and failure of repletion of nutrients, often leading to the maternal depletion syndrome which contributes to

---

[2] The most current data available is from the mid-1970s; however, it is assumed that this figure is still accurate.

early aging and death. Children are affected by low birth weight and increased risks of death.

Education

41. As noted above, literacy rates for women past school age are considerably lower than those for men and the gap widens with age from primary school onwards (see paragraph 31, above). Moreover, the drop-out rate for girls is significantly higher than for boys.

Economic Activities

42. Farming is the single most important occupation for rural women and they constitute 50 percent of all workers in agriculture and animal husbandry (not including their role caring for family backyard gardens). Despite their significant contributions in agriculture, women have limited access to land due to legal and social conventions. Only a small proportion of women own land or manage farms employing other labourers (women represent only 25 percent of farm managers). In the absence of collateral, they are unable to obtain credit from banks and are often by-passed by extension services geared towards larger producers and male farmers.

43. In the urban areas of Ghana, women have to deal with the numerous socio-economic constraints and problems of urban life, in addition to difficulties arising from their sex. Most women are engaged in the informal sector where their productivity is limited by, among other things, lack of access to institutional credit, appropriate technology as well as knowledge/information about markets and products.

Household Activities

44. In their role as managers of their households, women are overburdened by the time and effort required to collect fuel and water, prepare meals and take care of their children and other family members. In fact, they must perform these chores in addition to their productive activities. One study (Ewusi, 1987) has shown that women spend between 12-13 hours a day on income generation, domestic chores and community work.

Headship of Households

45. In many aspects of their life, the situation of women may actually worsen without effective countermeasures, for they may be increasingly becoming heads of households -- but without the same authority as their male counterparts. Data from the GLSS (1989) show that 24.8 percent, 33.9 percent and 26.3 percent of

households in Accra, other urban, and rural areas, respectively, are headed by females.

C. ANALYSIS OF PAST CO-OPERATION: 1986-1990

46. The Programme of Co-operation for the period 1986-1990 was formulated within the context of a bold Economic Recovery Programme (ERP I), which aimed at achieving macroeconomic stability and commencing the rehabilitation of social and economic infrastructure, which had deteriorated sharply over more than a decade of economic decline. While impressive progress was made in attaining macroeconomic targets, the impact of adjustment measures on vulnerable groups was initially not fully analyzed even though the Government was aware of the potential consequences. It was in the course of implementing the Programme of Co-operation that an innovative response was mounted through the Programme of Actions to Mitigate the Social Costs of Adjustment (PAMSCAD).

47. In the administrative sphere, Government's decision to decentralise authority and responsibility for development to District Assemblies marked an important departure from past practice. It also provided the stimulus for revitalising the Primary Health Care (PHC) strategy, by focusing on 25 of the 65 districts in 1985 (further increased to 110 districts from 1988-1989 onwards).

GOALS, OBJECTIVES AND PROGRAMME STRATEGIES

48. Within the overall goal of improving infant, child and maternal survival, the Programme of Co-operation aimed at:

a. reducing, first, the prevalence of infective and parasitic diseases through the Expanded Programme on Immunisation (EPI), safe water supply and sanitation, and malaria control; and, second, reducing the incidence of dehydration due to diarrhoea through Oral Rehydration Therapy (ORT);

b. reducing high neo-natal mortality through improved Mother and Child Health (MCH) services including the training of Traditional Birth Attendants (TBAs);

c. reducing the high levels of malnutrition among children and mothers through support for and promotion of weaning foods and preservation of foods;

d. promoting better child care through improved pre-school facilities and training of trainers and teachers; and

e. seeking ways and mobilising resources for effective dissemination of health knowledge to communities through health education and social mobilisation.

49. In view of UNICEF's limited resources and the various constraints imposed on the Government, an area specific approach was felt to be most appropriate for achieving synergistic impact. This meant a focus at the district level, specifically on the Government's PHC system, which operates from the district headquarters (Level C) through an intermediary supervising health centre/post (Level B) to the community (Level A).

50. It was therefore decided to integrate all UNICEF interventions in 15 of the 25 districts selected by the Government to begin PHC programmes, with more to be included after 1987. In addition, the Northern, Upper East and Upper West Regions, which were seen as most disadvantaged, were to be given special attention. Further, supply of vaccines and drugs, Control of Diarrhoeal Diseases (CDD) through the provision of Oral Rehydration Salts (ORS) sachets, and support for the measles campaigns retained a national scope.

51. It should be stressed that the proposed district-focused strategy of the 1986-1990 Programme was based on the key assumption that it would be supported by the rapid implementation of the Government's decentralisation policy and, thus, by considerably strengthened district level capacity for planning, implementation and monitoring.

IMPLEMENTATION EXPERIENCE

52. As early as the beginning of 1987, the focus of programme implementation shifted from the 15 PHC districts to all 65 districts in the country, in accordance with the Government's desire to promote PHC nationally. Only two administrative adjustments were introduced to facilitate this shift: 1) the Government assigned "Focal Persons" for the co-ordination of UNICEF assisted projects initially in each of the ten regions and subsequently in most of the 65 districts; and, 2) UNICEF programming shifted to the regional level with all UNICEF assistance co-ordinated by Programme Officers, each with responsibility for one to three regions.

53. Nonetheless, implementation of the administrative systems and procedures intended to facilitate decentralised, multi-sectoral planning and co-ordination, though formalised in policy documents, did not become fully operational immediately. In fact, implementation did not accelerate significantly until late 1989 with the establishment of District Assemblies and Regional Co-ordinating Councils.

54. The result was that UNICEF assistance became diffused and lacked the clarity and cohesion originally envisaged. UNICEF assistance was co-ordinated directly with the regional administrations without clear co-ordination at the national level. As

a result, sector ministries at the central level had little idea of what activities were actually taking place in each region and district.

55. The Mid-Term Review, held in July 1988, noted these concerns and recommended closer co-ordination and monitoring of UNICEF assistance within the context of the Government's decentralisation policy. The Mid-Term Review recommended, among other steps, the establishment of a Social Sector Co-ordinating Committee in each region with the responsibility of co-ordinating all inputs at the regional level, including those of UNICEF. The Mid-Term Review also noted the need for improved planning, preferably on a two year rolling basis. In practice, however, this proved difficult to implement, and the lack of a comprehensive plan agreed at all levels contributed to the relative lack of coherence of UNICEF assistance.

Expanded Programme on Immunisation

56. Following the revitalisation of the immunisation programme in 1985 with the measles campaign, the Expanded Programme on Immunisation (EPI) emerged as the major entry point for the enhancement of PHC in Ghana, backed by political commitment at the highest level for achieving UCI by 1990. While significant progress was made in developing and strengthening the cold chain system and flow of vaccines down to village levels between 1986 and 1988, it was not until 1989 that this progress was reflected in improved coverage rates based on sustainable delivery systems. According to routine Government reporting (based on an estimated target population of three percent of the total population), at the end of 1989 national vaccination coverage of children under one had reached 50.7 percent for the third dose of DPT vaccine, 65.3 percent for measles vaccine, 51.2 percent for the third dose of polio vaccine and 100 percent for BCG vaccine. The comparable figures for 1988 were 32 percent for DPT3, 45 percent for measles, 32 percent for Polio (OPV3) and 56 percent for BCG. The population denominator used in estimating vaccination coverage was, however, revised upward to 3.8 percent during 1990, indicating that actual coverage in 1989 may have been somewhat lower than suggested by the routine reporting data. Coverage estimates for 1990, when completed, will use a higher figure for the target population of children under one year of age.

57. While much of the groundwork has been laid for achieving UCI 1990 and maintaining such coverage thereafter, critical concerns remain, including the need to expand static and routine outreach services to cover all villages regularly (every two months), to involve all health institutions and staff in preventive health care, and to universalise society's demand and support for EPI services.

Control of Diarrhoeal Diseases

58. The introduction of locally produced ORS as of April 1988 created a basis for both private and public sector programming in the distribution and promotion of ORS as an effective means of diarrhoeal disease case management. NGOs and chemical sellers are actively involved, both in the distribution of ORS as well as the promotion of home made solutions. Prototype ORT education materials have also been developed and used extensively. Other promotional media such as dramas, posters, ORS packets with messages in seven local languages are also being used effectively.

59. Since 1988, UNICEF has not imported ORS into Ghana, but has instead imported raw materials for the local production of ORS totalling four million sachets. Since mid-1987, 500 health and non-health personnel have been trained in the use of ORT. UNICEF has supported Jaycees International in providing information on ORT to grassroots organizations in three regions, and some 720 teachers have been trained through these efforts.

60. With the standardisation of recommendations on ORT interventions at the household level and a more active involvement of health institutions and staff in preventive health care, the foundation has been laid for increasing awareness of ORT from the current 50 percent to at least 80 percent of mothers nationwide.

Training of Traditional Birth Attendants (TBAs)

61. Until 1987, the training of Traditional Birth Attendants (TBAs) and Village Health Workers, as well as the provision of basic supplies, was more or less left to the discretion of donors. The standardisation of TBA training in 1988, however, led to the establishment of a structure for ensuring the maintenance of the standard nationally and for spearheading the initiation of the Safe Motherhood Programme in seven districts in late 1989. Over 900 TBAs and 230 Community Clinic Attendants were retrained and over 530 TBAs and 210 Community Clinic Attendants were trained for the first time in the use of ORT.

62. The programme aimed at increasing access to and upgrading the quality of MCH services all over the country through TBA training and development. In 1989, 190 Level B trainers were trained and implementation now rests on the use of public health nurses and midwives at district levels to upgrade the skills of all Level B health staff as reinforcement for the training and supervision of 14,000 TBAs in the country by 1993.

Essential Drugs (Bamako Initiative)

63. Besides the on-going training of health staff at different levels and supply of Drugs and Dietary Supplements kits for health centres, health posts, midwifery

centres and Level A village health workers, it was possible to establish an essential drugs list. This has facilitated the recent introduction of the Government's "Cash and Carry" system of drug supply in the country and the launching of the Bamako Initiative in 1989 in five districts, one each in five regions. Operations research in all the five districts has recently been completed, guidelines for implementation established, as well as orientation meetings held.

Nutrition

64. Although approval of a National Food and Nutrition Policy has not proceeded as rapidly as expected, efforts in the area of weaning foods, food preservation and storage and establishment of nutrition surveillance centres have borne encouraging results.

65. All of the planned 45 weaning foods production sites have been established and strengthened in the 15 PHC districts initially selected. Subsequently, a nutrition surveillance system was also installed in one of the three weaning food sites in each district (21 in all); volunteers from each site were trained in weighing children and maintaining growth charts; supervising technicians were also trained in compiling and relaying records to Regional and National Headquarters. In 1987, 12 additional sites were identified for food processing and storage, two of which overlapped with the weaning foods sites.

66. Convinced of the benefits of the project (income generating opportunities and reduction of drudgery for women, better feeding of children, freedom for mothers to attend to other activities), the project was expanded to 55 additional sites. Some 50 production sites (for weaning food, food processing and storage) are in place and functioning well. Training has been provided to 60 technical officers from MOH and MLG, to 15 private district-level technicians and to one miller per community. Over 100 volunteers have been trained in growth monitoring in 21 communities and 110,000 growth charts have been printed locally. As of 1989, an estimated 60 percent of children were registered to use growth charts.

67. The chorkor smoker technology was also used successfully for fish smoking, initially in coastal and later inland regions. Dry season gardening in the northern sector was also attempted, where water supply schemes offered the opportunity.

Water and Sanitation

68. UNICEF assistance to the water supply and sanitation sector centred on co-operation with the Ghana Water and Sewerage Corporation (GWSC) to expand water and sanitation coverage. Significant resources were directed to improving water supply and sanitation in four regions (Brong Ahafo, Eastern, Volta and Western Regions). Activities in these regions included drilling 130 boreholes, and rehabilitation of 250 others, to serve health institutions, day care centres, nurseries

and primary schools. The programme sought to address needs throughout the country through improvement of water supply and sanitation in small communities, use of low technology and safe, affordable systems such as hand dug wells fitted with pumps and spring tappings (Henderson Boxes), as well as the rehabilitation of rain water harvesting systems.

69. In the initial years of the Programme, the focus was on the training of technicians, and supply of equipment, logistics and building materials for the drilling and rehabilitation of boreholes and harvesting of rain water for health institutions. Support for community-based supply of safe water and Kumasi Ventilated Improved Pit (KVIP) latrines were emphasised in subsequent years.

70. The issue of community animation and participation in planning, construction, operation and maintenance to create a sense of ownership has received special attention in the UNICEF sector programme. To this end, UNICEF has supported the local manufacture of pump parts, tools and materials; workshops and seminars on community participation and hand pump design; and institutional strengthening through local training.

Education

71. Only very limited support was provided in this sector, primarily to promote the establishment of a national policy on Early Childhood Development (ECD); however, this policy has not been finalised and adopted to date. Assistance was also provided in the form of basic equipment for a number of pre-school facilities. training of trainers for pre-school staff, and development of a programme to establish Integrated Community Centres for Employable Skills.

Social Mobilisation

72. Despite the availability of critical inputs to accelerate the achievement of UCI 1990, it had become clear by early 1988 that unless the constraining factors were analyzed and appropriate interventions initiated, Ghana stood a limited chance of realising the objective, given that vaccination coverage for all antigens stood at only 11 percent as of early 1988. In response to this challenge, UNICEF commissioned a KAP study on Social Mobilisation in 1988. The findings of the study were not only timely in terms of determining and establishing appropriate actions in support of CSD in general, but also in the formulation of appropriate strategies in support of the acceleration of activities relating to UCI 1990.

73. As a result, the period under review witnessed a surge in social mobilisation efforts, including the formation, in May 1989, of the National Social Mobilisation Committee for Child Survival and Development with representatives drawn from relevant governmental, non-governmental and international organizations and the mass media. The main function of the National Social Mobilisation Committee on

CSD is to initiate and co-ordinate actions to mobilise financial and human resources in support of CSD. Consistent with the Government's policy on decentralisation, Regional and District Social Mobilisation Committees on Child Survival and Development have been also established. The first social mobilisation workshop on CSD was held in mid-1989 and this was followed by regional and district workshops for over 800 participants. At the national level, a series of seminars attracted 132 participants. In 1990, activities were expanded to include production of a play in the Northern Region, a short television spot and a song on immunisation. In addition, the National Social Mobilisation Committee on CSD has produced a brochure and a poster on immunisation.

74. The impact of these developments is already being felt in the creation of demand and support for EPI. The potential, however, is considerable for addressing other child-related development issues such as literacy, Guinea worm eradication and dissemination of information pertaining to "Facts for Life" to communities.

Programme of Actions to Mitigate the Social Costs of Adjustment (PAMSCAD)

75. A major activity during the past programme cycle was to assess the impact of economic recession and adjustment policies on vulnerable groups, especially women and children, and to bring this to the attention of Government policy makers and the international donor community.

76. This advocacy effort led, in 1986, to the publication by UNICEF Ghana of a seminal report entitled "Adjustment Policies and Programmes to Protect Children and Other Vulnerable Groups". This report provided insights on three major issues: the impact of economic decline from the mid-1960s to the early 1980s on human welfare; the identity of the worst-affected groups; and the necessary elements of a programme for human recovery, within the context of structural adjustment. The analysis and information contained in the report played an important role in mobilising support for a concrete response to the identified problems and needs. Thus, at the meeting of the Consultative Group for Ghana in May 1987, the World Bank proposed a Programme of Actions to Mitigate the Social Costs of Adjustment (PAMSCAD) which was accepted by donors and subsequently developed by a multi-donor mission which visited the country in July 1987. After a Pledging Conference in February 1988, a programme costing US$ 85 million was launched later that year. At the time, PAMSCAD represented a unique development in Sub-Saharan Africa, bringing together the Government and donors to address the human dimensions of adjustment and economic recovery.

77. The programme was targeted at rural households (particularly in the Northern, Upper East and Upper West Regions), low-income, un- and under-employed urban households, and "redeployed" civil servants and employees of public and private

enterprises. The principal categories of projects included: community initiative projects; employment generation; assistance to the redeployed; basic needs (health, nutrition, water and sanitation, shelter); and education. UNICEF's contribution to PAMSCAD was divided between an essential drugs project (Bamako Initiative) and a project for enhancing the opportunities for women in development (in collaboration with UNDP, UNFPA, UNIFEM and USAID).

78. After a very slow start, implementation of PAMSCAD began on a large scale in 1990. Thus, even though only 14 Community Initiative Projects (CIPs), out of a planned 1000, had been completed by March 1990, 290 million Cedis had been released to an additional 198 projects. Furthermore, the MFEP-PAMSCAD Unit had approved the release of 406 million Cedis for another 626 projects. To take another case, 250 million Cedis was released during the first quarter of 1990 for the Agricultural Rehabilitation Credit Project, about 50 percent of which had been disbursed by July 1990.

79. With respect to the UNICEF-assisted projects, despite an initial delay in the disbursal of funds, implementation was well underway by mid-1990. In the area of essential drugs, five districts had been selected as project areas, baseline surveys had been completed and district-level orientations held, supported by the arrival of a large consignment of drugs in February 1990. In the women's project, all funds will be disbursed by the end of 1990, primarily for the purchase of project vehicles, training, the establishment of a credit line and further support for income-generating activities. Assistance has also been provided for the creation of a Women in Development (WID) Secretariat within the Ministry of Local Government (MLG).

80. The foundation has, therefore, been laid for the accelerated implementation of UNICEF-assisted projects in late-1990 and early 1991. In addition, it should be noted that the latter straddle both the 1986-1990 and the 1991-1995 Programmes of Co-operation. In the new Programme of Co-operation, PAMSCAD activities are fully merged with all other programme interventions.

81. Notwithstanding notable programme-wide progress during 1990, almost a third of the 23 projects within PAMSCAD have yet to provide any assistance/service to their target groups. Furthermore, as of mid-1990, only about 4.6 billion Cedis had been disbursed by donors out of the 14.5 billion Cedis budgeted for the Programme.

82. The performance of PAMSCAD was the subject of an internal Government evaluation in early 1990, the results of which were made available in a report published in May 1990. The Government's assessment served as the basis for a donor mission which reviewed progress on PAMSCAD in August 1990. The mission's objective was to "...identify solutions to design and implementation problems,...to expedite implementation and direct a larger proportion of resources to vulnerable groups."

83. Some of the key problems identified by the donor mission included:

a. The complex structure of the programme with too many projects scattered both geographically and across sectors -- 23 projects are being implemented by 13 different agencies/departments in nine sectors;

b. Inadequate targeting, with a clear urban bias in the location of project sites, limited emphasis on the socio-economic and gender characteristics of beneficiaries and neglect of regional differences;

c. The slow pace of implementation -- only approximately $15.6 million equivalent (or 18 percent of the programme budget) had been made available by donors one year after the Pledging Conference;

d. The excessive concentration of decision-making within central ministries, for example, in the disbursement of funds and the "...development of criteria...for the selection of project activities";

e. Excessive emphasis on institution-building, "...creation of new project units, purchase of vehicles...and technical assistance...", mostly at the centre -- 48 percent of disbursements as of mid-1990 had been used for this purpose;

f. The absence of high-level leadership in the management of the Programme; and

g. Rudimentary monitoring of implementation, as indicated, for example, by the absence of a standardised format for data collection.

84. The principal recommendations of the donor mission were:

a. to concentrate on the implementation of a few high pay-off projects -- the Community Initiative Projects (CIPs), Hand Dug Wells and Low Cost Sanitation, Agricultural Rehabilitation Credit and Non-Formal Education;

b. to impart momentum and direction by placing "....responsibility for leadership and policy oversight....under one PNDC Secretary";

c. to target more effectively "....through geographical focus on the most needy regions and a limited number of districts and villages" as well as a strengthened focus on women;

d. to clarify responsibilities at the different administrative levels, with initiation and implementation at the district level, approval authority at the regional level and supervision and monitoring at the national level; and, finally,

e. to reduce the number of donors per project - currently, 11 out of the 23 projects are being funded by three or more donors.

85. The mission also broached certain broader considerations which are not only relevant to Ghana but also other countries in Sub-Saharan Africa which have already embarked upon or are planning to initiate PAMSCAD-type programmes. They include the following suggestions:

a. Ensure the integration of PAMSCAD institutions with "....the requirements of more comprehensive and longer-term poverty alleviation programs....," otherwise "....there is a risk that PAMSCAD-specific institutions, and even some of the projects, may continue to claim scarce Government resources and impede efforts to address the needs of the poor in a systematic manner";

b. Explore the possibility of implementing part of the programme through Non-Governmental Organizations (NGOs);

c. Define projects "....on the basis of program objectives (e.g. assistance to the rural poor and redeployees) rather than independent sectoral inputs (e.g. agriculture, health, education)...." to avoid the proliferation of projects;

d. Address likely institutional constraints - the manpower-intensive nature of projects designed to reach vulnerable groups, the difficulty of building upon existing programmes and the pressure for institution-building at the centre; and

e. Take into consideration the difficulty of securing additional funds and achieving a simplification of donor procedures.

86. The donor mission concluded its work at a wrap-up meeting with the Government, chaired by the PNDC Secretary for Finance and Economic Planning, and including representatives from the implementing agencies. This meeting demonstrated considerable agreement between the Government and donors on problems and the relevant solutions. For example, the PNDC Secretary indicated that attention should be given to a narrower range of projects, better targeting and the clarification of responsibilities at different administrative levels.

87. The draft report of the mission has been released for comments and will be finalised by mid-October 1990. Once this process is completed, the principal task will be the implementation of the recommendations by the end of 1990, at the latest. As it did during the mission, UNICEF will play an active role in the follow-up activities designed to strengthen the impact of PAMSCAD on vulnerable groups.

LESSONS LEARNED

88. The experience of the last several years has highlighted a number of lessons which must be taken into account in planning future UNICEF assistance in Ghana:

a. Dispersal of resources over a large number of project areas and the lack of integration of programme components significantly reduces the impact of interventions;

b. The effectiveness of programmes depends, to a large measure, on the availability of financial and human resources at all levels as well as the existence of supportive systems and procedures within and between different levels of service delivery;

c. Programme formulation and implementation must rely upon a clear definition of several factors: constraints, including gaps in knowledge; hierarchy of project impact, coverage and output objectives; and, in relation to the latter, a system to monitor the progress in achieving objectives; and

d. Sustainable development within available means necessitates programmes which respond to felt needs and are based on the active involvement of communities in decision-making, resource mobilisation and monitoring of progress.

89. The above points clearly suggest that the new Programme of Co-operation must operate on the basis of a national framework which:

a. Maximises the complementarity of programme components to effectively address identified problems and felt needs; and

b. Contributes to a process which not only improves capacity for programme formulation, implementation and monitoring, but also encourages intersectoral co-ordination and a high level of community involvement.

D. OVERVIEW OF THE 1991-1995 PROGRAMME OF CO-OPERATION

90. The 1991-1995 Government/UNICEF Programme of Co-operation is based on strategies and courses of action contained in the present Master Plan of Operations. The overall Programme of Co-operation is conceived as an integrated whole addressing the needs of children and women at all levels of society. All programmes and projects described in the Master Plan of Operations therefore support and strengthen each other.

91. The Programme of Co-operation presented here is the result of extensive consultations between UNICEF and the Government during the first half of 1990. District-level interventions will be further refined during the first year of programme implementation as baseline studies and community-based needs assessments are carried out and the findings used to identify the specific mix of interventions to be implemented.

92. The Plan of Operations is divided into five sector programme areas which provide the major outline of the interlocking framework of services and interventions. Specific projects within each sector programme address needs which have been identified in concert with the Government and each project is, in turn, divided into its component activities.

COUNTRY PROGRAMME GOALS

93. Together, the sector programmes and projects seek to contribute to a significant enhancement of the well-being of children and women in Ghana, with the following general goals:

a. Reduction of the Under Five Mortality Rate (U5MR) by 16 percent to approximately 134 per thousand live births in 1995;

b. Reduction of the maternal mortality rate by 25 percent;

c. Improved access to and achievement of basic education for Ghanaian children and improved literacy for women;

d. Enhanced capacity for planning and implementing social development initiatives, especially at the district and community level, with emphasis on involving women; and

e. Enhanced health knowledge, based on "Facts for Life", among parents, especially mothers.

STRATEGIES FOR CHILDREN AND WOMEN IN GHANA: 1991-1995

94. The 1991-1995 Programme of Co-operation has been formulated within the context of Ghana's national social policies and within the framework of the Strategies for Children in the 1990s articulated in UNICEF's Medium Term Plan (E/ICEF/1990/3; 22 February, 1990).

Government of Ghana Goals and Policies

95. As stated in the 1989-1991 Public Investment Programme (PIP), the Government of Ghana aims to improve the quality of life of all Ghanaians through economic growth based on, inter alia: a stable macroeconomic framework (entailing internal and external balance); elimination of distortions in factor and product markets; the gradual withdrawal of the state from most directly productive activities and the encouragement of the private sector; substantial investment in social and economic infrastructure; and an economy well integrated with global markets.

96. A number of goals are also proposed by the Government in the programme of action prepared in response to the Decade of the African Child declared by the Organisation of African Unity at its 1989 Summit. In this document, the Government pledges itself to accelerate programmes in the areas of, for example, early childhood development, literacy and education, childhood disabilities and health.

UNICEF Medium Term Plan

97. In the Medium Term Plan approved by the UNICEF Executive Board (E/ICEF/1990/3), UNICEF has identified seven major goals for children globally to be achieved by the year 2000:

a. Reduction of infant and under five mortality rates in all countries by one third, or to 50 and 70 per 1,000 live births, respectively;

b. Reduction of the maternal mortality rate by one third between 1990 and the year 2000;

c. Reduction of malnutrition among children under five by one half;

d. Universal access to safe drinking water and to sanitary means of excreta disposal;

e. Universal access to basic education and completion of primary education by at least 80 percent of primary school-age children; and

f. Reduction of the adult illiteracy rate to at least one half its 1990 level with an emphasis on female literacy.

98. Within this context, UNICEF will continue to advocate for a strong social dimension to be included in all short- and medium-term economic planning, stabilisation and adjustment measures, as well as in long-term development. The Organisation will, therefore, encourage countries to move beyond "Adjustment With a Human Face" to "Development With a Human Face" as part of the international development strategy for the Fourth United Nations Development Decade.

99. Activities in this area will seek to encourage and support, in a limited number of countries, inter-ministerial task-forces to prepare social action and social investment programmes; to influence the policy dialogue on redesigning fiscal, price and investment policies to give these policies a bias in favour of the poor; to stimulate national debates through workshops; and to support the formulation of an international development strategy, as its input into the Fourth United Nations Development Decade, that advocates "Development With a Human Face."

100. Based on the above general policy framework, on UNICEF's country programme approach and on the 1989-1990 Situation Analysis, a number of general strategies have been adopted in the new Programme of Co-operation in order to attain the overall programme goals. These strategies include the following:

a. Focus on the Primary Health Care approach enunciated at the Alma Ata Conference in 1978, with specific emphasis on controlling child-killing diseases through Universal Child Immunisation and use of Oral Rehydration Therapy;

b. Adherence to the Bamako Initiative principles of community financing to help ensure the sustainability of Primary Health Care;

c. Recognition of the role of women as essential agents of change and key initiators, planners, and implementers of development activities, in addition to benefiting from those activities;

d. Emphasis on the importance of adequate maternal and child nutrition as a means of ensuring survival and development; and

e. Use of mobilisation and advocacy to build alliances and put essential health knowledge into the hands of policy-makers and parents.

101. Each of these strategies is integrated with and mutually supportive of the others and, as such, does not necessarily represent a discreet programme or project within the new Programme of Co-operation. Rather, the strategies should be viewed as approaches which underlie all the programmes, projects and activities with a view to maximising their overall impact on the welfare of children and women in Ghana during the 1991-1995 Programme of Co-operation.

102. Three of these strategies (involvement of women, community participation and financing, and institutional capacity building) deserve special attention as they are crucial to the success of all programmes and projects in the 1991-1995 Programme of Co-operation, but do not have specific programmes or projects linked to them. Each of these strategies is described in more detail below.

Women and Development

103. Whereas the past Programme of Co-operation included a specific group of activities labelled as "women's activities," the 1991-1995 Programme of Co-operation will emphasise, instead, the central role of women in all development activities affecting children and families. The Programme recognises that, for all children in Ghana, the mother will be the principal if not the only health provider in the first years of life. For this reason, any programme to reach children must necessarily improve the welfare of mothers first. Women play a crucial role in Ghanaian society, often as the heads of their households, as economic producers and as key mobilisers in the community. For these reasons, the health, nutrition, welfare and education of women are of central concern in the development of all programmes and projects and, thus, the latter will be formulated to maximise the benefit to women.

104. Within the framework of its national laws and the international conventions to which it has acceded, Ghana has committed itself to upholding the equality of women and men and the elimination of gender disparities and all forms of discrimination against women. Within this framework, and in light of the recent socio-economic crises and the resulting deterioration in the living conditions of vulnerable groups, especially women, the Programme of Co-operation will address the situation and development needs of women through a multi-pronged approach built around a variety of interventions in each programme.

105. Special attention will be given to strategies which address the critical concerns of women in terms of a) knowledge, information, education and training; b) fertility management; c) workload reduction and time-saving; d) income generation and employment; and e) decision-making and effective participation in programme planning, management and implementation. Mobilisation and advocacy will be utilised to promote positive responses on the part of co-operating partners and collaborators (including men and men's organizations and groups) to the above concerns. At the same time, successful interventions in any of the areas mentioned above will be used for advocacy and social mobilisation.

Community Participation and Financing (Bamako Initiative)

106. The Government and UNICEF have both committed themselves to strengthening MCH and PHC services in Ghana within the context of the Bamako Initiative, which was launched in response to a resolution of the African Ministers of

Health at their Regional Committee meeting in 1987. The thrust of this strategy is to increase access to MCH and PHC services through the decentralisation of health decision-making to the district level; promotion of community level management of PHC in accordance with the recommendations of the 1978 Alma Ata Conference; and user financing of essential generic drugs and services to generate local capital to expand and sustain PHC services at the community level. The Essential Drugs Programme, launched in five districts in Ghana in 1989, will be expanded during the new Programme of Co-operation to cover five additional districts. At the same time, the focus will shift from simply providing generic drugs as "seed capital" to ensuring full complementarity with the Government's drug supply scheme ("Cash and Carry") and use by the community of the funds generated from the sale of drugs to support other PHC-related interventions included in the present Programme of Co-operation. The strategy will be closely linked with the Health and Nutrition, Social Mobilisation and Planning Monitoring and Evaluation Programmes at the national level and will form an essential part of the comprehensive package of PHC and other essential services in the ten districts targeted for full integration of services.

Institutional Capacity Building

107. UNICEF assistance will, in the 1991-1995 Programme of Co-operation, be administered increasingly in the context of the Government's policy of decentralising responsibility for administration and social service delivery. To this end, UNICEF will focus its efforts on the improvement of institutional capacity, especially at the district, area and community levels, to identify gaps and needs and to respond at the local level through the planning, implementation and monitoring of programmes for the benefit of children and women. The full involvement of Government counterparts in the preparation of the 1991-1995 Programme of Co-operation has already yielded positive results in terms of improved co-ordination within Government agencies and between these agencies and UNICEF. It is anticipated that this collaboration will continue and expand to include more regular involvement of the regional and district administrations in all phases of programme planning and monitoring.

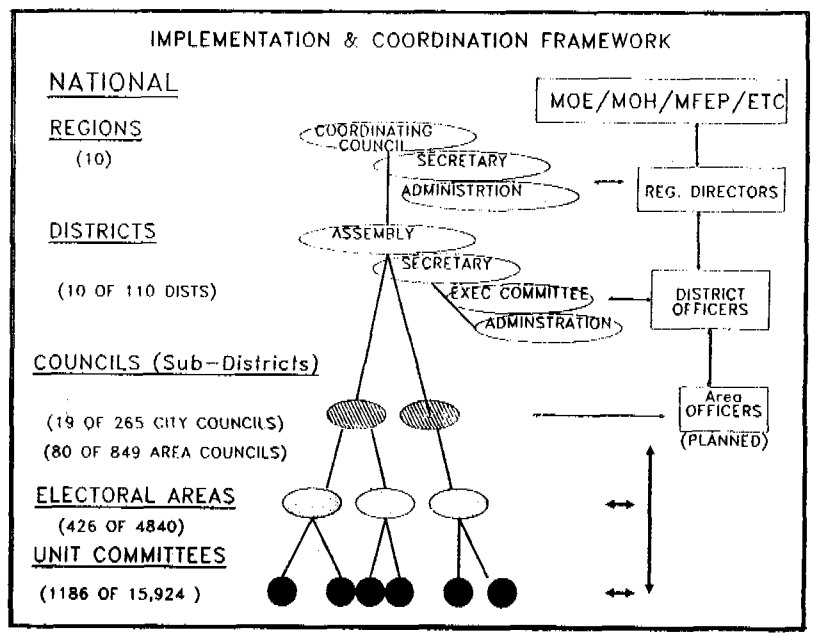
GEOGRAPHIC COVERAGE

108. The overall Country Programme will seek to improve the quality and coverage of basic social services to all children and women in Ghana. Every programme within the Programme of Co-operation will provide support at the national level to ministries, quasi-governmental institutions and NGOs to assist them in expanding the coverage and quality of basic services in each of the programme sectors described in this Master Plan of Operations.

109. The Programme of Co-operation will be comprised of activities at three levels: national, regional and district. At the national level, projects such as EPI/ORT, National Food and Nutrition Policy Development and programmes such as Social

Mobilisation and Planning, Monitoring and Evaluation will seek to improve policies, knowledge and infrastructure to benefit all children and women in the country. At the regional level, selected activities such as Support for Safe Motherhood, Control of IDD and Rural Water Supply (Guinea Worm Eradication) will focus on problems in specific regions to address localised problems or to complement the assistance of other donors in other parts of the country. At the district level, ten districts have been selected for the convergence and integration of UNICEF assistance. In these districts, all the activities within the Health and Nutrition, Basic Learning Needs and Water and Sanitation Programmes will be carefully co-ordinated to ensure full complementarity and maximum impact. The District PHC Development Project will focus on these same ten districts, however its activities will be phased in gradually in a limited number of districts in each of the first three years of the Programme of Co-operation (e.g., two districts in 1991, three more in 1992 and the final five in 1993).

110. The targeting of a significant portion of sector programme funds on ten selected districts is specifically designed to avoid the dispersion of UNICEF resources that occurred during the previous Programme of Co-operation. Following the Strategy Formulation Meeting in March 1990, the Ministry of Finance and Economic Planning (MFEP) requested each of the ten Regional Secretaries to identify one district within each region which would serve as a model for the integration of PHC and basic services. UNICEF efforts at the national level will be co-ordinated by the MFEP and by each sector ministry, and UNICEF staff will follow-up on the national sectoral programmes with each regional administration. The goal will be to achieve a synergistic effect and to ensure both horizontal and vertical linkages between and among the various UNICEF-assisted sector programmes at the local level.



111. Within each district, the establishment in 1990 of Unit Committees, each covering a population of 1,000 inhabitants drawn from a number of small villages, provides an institutional basis for ensuring that services actually reach the intended beneficiaries. At the sub-district level, administrative structures are currently limited to health centres/posts (Level B) of the Ministry of Health; however, PNDC Law 207 on Government decentralisation envisages the establishment of sub-district administrative offices (Town and Area Councils). Some 19 Town and Area Councils already exist in the selected districts, and these will be the focus of UNICEF-assisted efforts during the first year of implementation (1991). The Town/Area Councils will be fully established during the next several years and will provide an opportunity for effective planning and co-ordination of social development interventions. UNICEF assistance is specifically intended to support and strengthen Government efforts to implement this step in the process of decentralisation.

112. The ten districts selected by the Government for implementation of geographically integrated national programmes are as follows:

Region	District	Population*	Number of Town/ Area Councils (Sub-districts)	Number of Unit Committees
Ashanti	Ashanti-Akim	85,000	10	52
Brong Ahafo	Asunafo	124,000	13	171
Central	Assin	145,000	14	161
Eastern	Manya	150,000	12	182
Greater Accra	Dangbe West	83,000	7	99
Northern	Yendi	83,000	6	78
Upper East	Builsa	67,000	8	91
Upper West	Lawra	74,000	8	115
Volta	Jasikan	120,000	8	147
Western	Sefwi Wiawso	69,000	7	87
TOTAL		1,000,000	93	1,183

* Based on 1984 National Census.

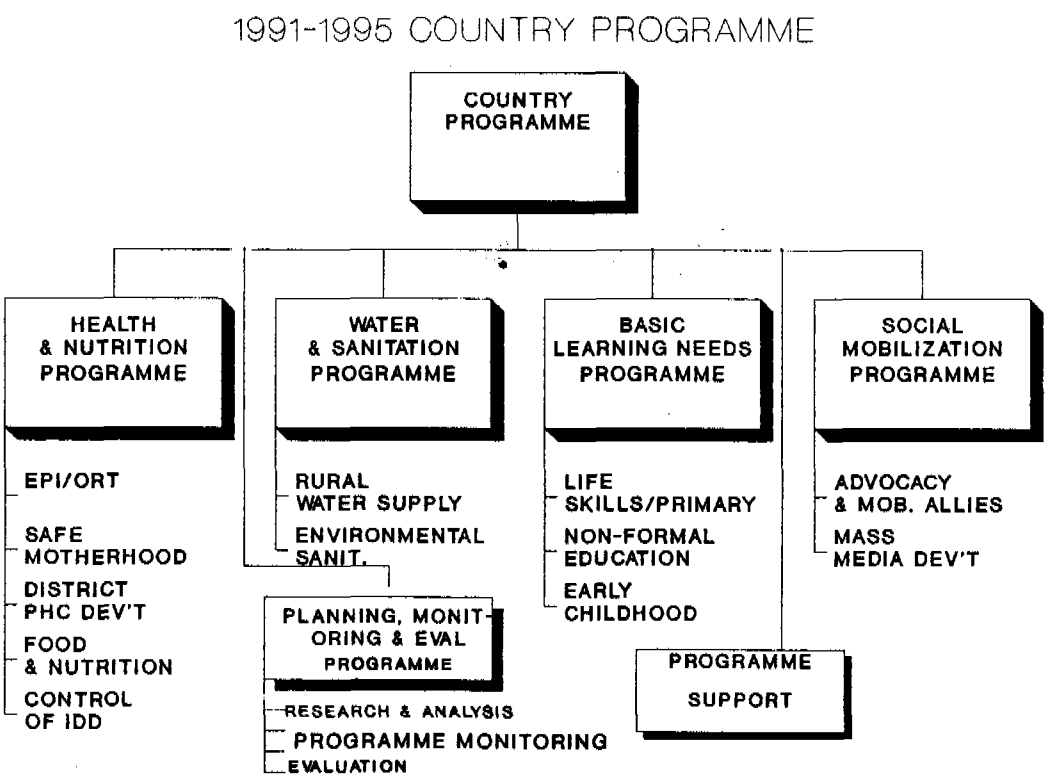
113. Interventions in each district will begin with baseline studies and participatory research to determine, in consultation with each Unit Committee, the needs of its population. This will be followed by the gradual implementation of programmes to benefit the population of all Unit Committees in each district (though not necessarily each village within each Unit Committee). As noted above, during the first year, efforts will concentrate on the Unit Committees covered by the 19 Town/Area Councils which already exist in the ten districts. In subsequent years,

implementation will expand until, by the fifth year, all Town/Area Councils and Unit Committees in the ten districts have benefited from the Country Programme.

114. Although activities will not necessarily take place in each village within a Unit Committee's area, it is expected that the close geographic proximity of the villages,combined with the fact that members of all communities will participate in Unit Committee meetings, will ensure the replication of successful approaches developed at the sub-district level.

PROGRAMME STRUCTURE

115. The Programmes and Projects within the 1991-1995 Programme of Co-operation will be grouped as follows:



CO-ORDINATION AND MANAGEMENT OF THE COUNTRY PROGRAMME

116. UNICEF assistance to the Government will be co-ordinated at the national level by the Ministry of Finance and Economic Planning (MFEP) together with the relevant sector ministries (for example, the Ministry of Health) and other Government institutions such as the NDPC and GWSC. The MFEP will also help to ensure adequate co-ordination with other donor organizations in order to reduce duplication of efforts and ensure maximum impact on the beneficiary populations. In all programmes and projects targeted at the regional and district levels, the Regional and District Administrations (Ministry of Local Government) will co-ordinate and monitor project implementation by the decentralised sector ministries.

117. Effective collaboration with other national, international and bi-lateral agencies will be a major goal of advocacy activities in order to help ensure that successful models of interventions are expanded and "taken to scale" either with or without UNICEF assistance.

MONITORING AND EVALUATION

118. The 1991-1995 Programme of Co-operation will stress effective monitoring and evaluation as a central strategy. All programmes will be based on national and district baseline studies, to be carried out beginning in 1991 as part of the Planning, Monitoring and Evaluation Programme. The district baseline studies will be carried out in the ten districts selected for the convergence of UNICEF assistance and will be phased in together with the District PHC Development project (e.g., two districts in 1991, three in 1992 and five in 1993). These studies will yield data on key indicators to be used in assessing programme coverage and impact and will provide the basis for continuous monitoring related to the health and welfare of children and women.

119. In terms of implementation, UNICEF will monitor its programme inputs on a continuous basis using the Global Field Support System and other custom-designed computer software. This will be complemented by extensive field visits by UNICEF staff, especially to the ten targeted districts. These information systems will provide the basis for quarterly UNICEF implementation reviews and for Annual Planning and Review Meetings to be conducted under the leadership of MFEP in December of each year.

120. Each major programme will be evaluated at least once during the five year programme cycle. These evaluations will be conducted by UNICEF staff and consultants and will include Government and donor participation as appropriate. All evaluations will be used in preparing the 1996-2000 Programme of Co-operation. UNICEF will also carry out "mini evaluations" annually as part of its regular process of reporting to donors on the progress of Supplementary Funded projects.

121. A Mid-Term Review will be held in mid-1993 based on the first round of programme evaluations and the regular monitoring of indicators. This Review will assess the overall progress of the Programme of Co-operation against its objectives, and will recommend any necessary modification or reorientation of the overall programme or of specific projects and activities.

COLLABORATION WITH OTHER UN AND BI-LATERAL AGENCIES

122. As noted above, the resources available to UNICEF for use in Ghana are extremely limited when compared to those available to Government and other donors. For this reason, UNICEF will seek to use its funds as a catalyst to promote more collaborative and, therefore, effective use of resources by the Government and other donors. Central to this strategy will be the promotion of improved inter-sectoral collaboration among Government ministries at the national, regional and local levels, as well as closer co-operation with other national and international agencies with necessary capacity and resources. International agencies, including the African Development Bank, UNDP, UNESCO, WHO, and the World Bank, and bilateral agencies, including CIDA, Japanese International Co-operation Agency (JICA), USAID and others, have collaborated in the preparation of the Programme of Co-operation. Representatives of all the above donors were involved in the Programme Strategy Meeting held in March 1990 and also participated in the Programme Preview Meeting in June 1990. A primary goal of this co-operation are to reduce unnecessary duplication of efforts, promote the replication of effective and cost-effective interventions, and mobilise additional resources to benefit women and children.

COUNTRY PROGRAMME BUDGET/TIMEFRAME

(THOUSANDS OF US DOLLARS)

PROGRAMMES	1991	1992	1993	1994	1995	TOTAL
HEALTH AND NUTRITION						
General Resources	643	748	876	850	961	4078
*Funded Sup. funding	510	0	0	0	0	510
Unfunded Sup funding	817	854	1269	1244	821	5005
Total	1970	1602	2145	2094	1782	9593
BASIC LEARNING NEEDS						
General Resources	387	428	355	366	389	1925
*Funded Sup. funding	0	0	0	0	0	0
Unfunded Sup funding	0	223	376	458	406	1463
Total	387	651	731	824	795	3388
WATER AND SANITATION						
General Resources	298	326	319	277	259	1479
*Funded Sup. funding	0	0	0	0	0	0
Unfunded Sup funding	219	432	467	521	393	2032
Total	517	758	786	798	652	3511
SOCIAL MOBILISATION						
General Resources	260	325	270	225	225	1305
*Funded Sup. funding	0	0	0	0	0	0
Unfunded Sup funding	0	0	0	0	0	0
Total	260	325	270	225	225	1305
PLANNING, MONITORING & EVALUATION						
General Resources	257	91	157	242	107	854
*Funded Sup. funding	0	0	0	0	0	0
Unfunded Sup funding	0	0	0	0	0	0
Total	257	91	157	242	107	854
PROGRAMME SUPPORT						
General Resources	480	407	348	365	384	1984
*Funded Sup. funding	0	0	0	0	0	0
Unfunded Sup funding	0	0	0	0	0	0
Total	480	407	348	365	384	1984
TOTAL COUNTRY PROGRAMME						
General Resources	2325	2325	2325	2325	2325	11625
*Funded Sup. funding	510	0	0	0	0	510
Unfunded Sup funding	1036	1509	2112	2223	1620	8500
Total	3871	3834	4437	4548	3945	20635

* NOTE: Projections of Supplementary Funds on hand as of 30 September, 1990.

SECTION II:

PROGRAMME PLANS OF OPERATIONS

HEALTH AND NUTRITION PROGRAMME

SUMMARY

123. The Health and Nutrition Programme aims at contributing to the reduction of under five and maternal mortality through:

a. country-wide support for national EPI/ORT coverage, the development of a food and nutrition policy and control of iodine deficiency disorders in goitre-endemic areas;

b. development of a comprehensive, integrated and community-based PHC system, initially in ten districts, one in each of the country's ten regions; and

c. region-specific support to strengthen the Government's national Safe Motherhood Programme in three regions.

124. These interventions, and the support systems within them, have evolved from past programme experience in Ghana and are in concurrence with the strategies underlying the Bamako Initiative. They provide the basis for the strategic thrust of UNICEF collaboration during the period 1991-1995 which aims at promoting effectiveness and efficiency in service delivery while, at the same time, ensuring sustainability of services through the involvement of communities in the planning and implementation of health and other development initiatives.

BACKGROUND

The Problem

125. Ghana has an under five mortality rate of 155 per 1000 live births. Almost 60 percent of these deaths are caused by preventable causes including measles (12.6 percent), pneumonia (9.1 percent), low birth weight (8.2 percent), malaria (7.2 percent), anaemia (6.8 percent), diarrhoea (6.6 percent), kwashiorkor (3.4 percent), marasmus (2.7 percent), and tuberculosis (0.6 percent). Maternal mortality is 5-10 per 1,000 live births mostly caused by obstetrical complications (bleeding, obstruction and infection) and compounded by such pre-natal problems as malaria and anaemia. About 28 percent of these deliveries are assisted by traditional birth attendants, 24 percent by relatives and 7 percent totally unassisted.

126. Malnutrition among children and women is also widespread: According to the National Nutrition Survey (1986), among children 0-60 months of age, 40.3 percent are below 80 percent of the US-NCHS weight-for-height standard, 51.5 percent are

below 90 percent of the height-for-age standard, and 8 percent are severely malnourished. With respect to women, 36 percent are severely under-weight during the "lean season", and 19 percent during the rest of the year. Among women tested at pre-natal clinics in 1987, 69 percent were found to be anaemic by WHO standards. The Total Fertility Rate of 6.4 compounds the grave effects of maternal malnutrition, with almost a fifth of infant deaths caused by low birth weight.

127. Inadequate intake of nutrients which results from the lack of food at the household level or the inability to buy food, is exacerbated by the interplay of various factors such as inappropriate traditional feeding practices and food taboos which are sustained by the high illiteracy rate of 77 percent among females nine years of age and older.

128. Attempts to address these problems are hampered by weaknesses in the health delivery system. Coverage of services is low: 40 percent of the national and 55 percent of the rural population do not have access to health facilities; 73 percent of the national and 85 percent of the rural population do not have sanitation facilities; and about half of the national population does not have access to potable water.

129. Health planning and management are undermined by a number of factors: unintegrated organisation and delivery of services; over-centralised operations; limited community participation; non-existent monitoring and evaluation systems; and insufficient manpower planning and training.

130. Moreover, steps to implement a three-tier Primary Health Care (PHC) system - comprising Level A (community), Level B (health centre/post) and Level C (district) - have been constrained by the relative lack of success in increasing expenditure on PHC: the latter's share in Government health expenditure increased from 22 percent in 1987 to only 24 percent in 1989.

Government Policies and Structure

131. The Government's policy is to provide basic health care on a universal basis by strengthening the PHC system, using the district as the basic unit for the administration of health services. This policy is being pursued through the rehabilitation and upgrading of facilities and the provision of essential drug supplies through the retention by health institutions of 100 percent of fees collected from patients and the introduction of a "cash-and-carry" system which allows Level A and Level B health facilities to purchase drugs from Level C facilities. The income generated as a result will be used to establish a revolving fund for the purchase of essential drugs. Steps are also being taken to strengthen and improve health information systems, planning, management, evaluation and manpower development, as well as rationalise collaboration between health and the other

social sectors. The Ministry of Health (MOH) is currently being restructured with a view to achieving these objectives.

132. Regarding food and nutrition, the Medium-Term Agricultural Development Programme of the Ministry of Agriculture (MOA) for 1990-1995 offers some hope of improving upon the existing situation in the country. One of its objectives 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 MOA hopes to achieve this objective by encouraging the growth of smallholder food production through adoption of appropriate technology, strengthening of extension services, provision of necessary inputs and the construction of feeder roads.

133. A National Food and Nutrition Policy, drafted in 1984, is currently being considered for review and finalisation during 1991. The draft deals with 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 programmes.

PAST CO-OPERATION

134. Important advances have been made in the areas of EPI and ORT,and it has been demonstrated that significant proportions of the target population can be reached by bringing health services to communities and mobilising the involvement of all sectors of society to promote better health. Besides the need for increasing EPI coverage to 80 percent and maintaining such coverage every year thereafter, the continuation of EPI/ORT activities provides the opportunity to gradually incorporate efforts to control malaria and acute lower respiratory infections. Other interventions, including TBA training, weaning food production, storage and preservation and growth monitoring have made a substantial contribution in laying a foundation for the future. However, they have remained too fragmented and thinly spread to significantly improve nutritional status by themselves. These lessons have necessitated a change of orientation in the proposed Programme of Co-operation as described in the Programme Strategy (see below).

Expanded Programme on Immunisation

135. Following the revitalisation of the immunisation programme in 1985 with the measles campaign, EPI has emerged as the major entry point for the enhancement of PHC in Ghana. While significant progress was made in developing and strengthening the cold chain system and flow of vaccines down to village levels between 1986 and 1988, the major stride in immunisation did not occur until 1989 when, backed by political commitment at the highest level for the achievement of UCI 1990, 93 percent of children under one year of age could be reached by health staff delivering EPI services at least once. Third dose coverage still stands at 60

percent (DPT3, December 1989), essentially because of inadequate number of fixed centres and the resulting dependency on campaigns with long intervals.

Control of Diarrhoeal Diseases

136. The introduction of locally produced ORS as of April 1988 created a basis for both private and public sector programming in the distribution and promotion of ORS as an effective means of diarrhoeal disease case management. NGOs and chemical sellers are actively involved, both in the distribution of ORS as well as the promotion of home-made solutions. A recent survey (GDHS 1989) shows that 33.5 percent of children with diarrhoea were treated with ORS and 6.1 percent with home solutions.

Primary Health Care/MCH

137. Until 1987, the training of Traditional Birth Attendants (TBAs) and Village Health Workers and the provision of basic supplies were more or less left to the discretion of donors. The standardisation of TBA training in 1988, however, led to the establishment of a structure for ensuring the maintenance of the standard nationally and for spearheading the initiation of the Safe Motherhood Programme in seven pilot districts in late 1989.

138. Besides the on-going training of health staff at different levels and supply of drugs and dietary supplements (D&DS) kits for health centres, health posts, midwifery centres and Level A village health workers, it was possible to establish an essential drugs list. This has facilitated the recent introduction of a "cash-and-carry" system of drug supply in the country, and the launching of the Bamako Initiative in 1989 in five districts, one each in five regions. Operations research in all the five districts has recently been completed, guidelines for implementation established as well as orientation meetings held.

Nutrition

139. Several attempts have been made in collaboration with Governmental and non-governmental organisations to address the problem of malnutrition. Among these attempts has been the Weaning Food, Storage and Processing Project (WFSPP) which primarily aimed at addressing inappropriate traditional feeding practices that led to growth faltering. The nutritional status of children in project sites appears to be improving. In addition, the grinding machines provided by the Project offered women's groups concrete opportunities for reducing their labour, besides generating income. Other attempts included dry-season gardening, and nutrition rehabilitation accompanied with growth monitoring and counselling of mothers. An evaluation and analysis of the Project will need to be finalised to determine whether or not the Project has had a significant impact.

PROPOSED PROGRAMME

140. The Health and Nutrition Programme represents a consolidation of past co-operation and builds on the lessons gained in the process. It blends with existing national policy and operational framework and addresses the constraints encountered in the previous Programme of Co-operation, especially the thin spread of vertical interventions and inadequacy of capacity at the district and community levels to effectively promote health. This has led to the selection of the following programme components:

a. the continuation of an integrated nationwide EPI/ORT intervention to address the causes of one third of all child deaths and gradually incorporate prevention and cure of malaria and ARI during vaccinations;

b. the development of a comprehensive PHC system in ten districts, one in each of the ten administrative regions, to ensure an integrated package of interventions addressing all direct causes of child and maternal morbidity and mortality as well as establish entry points for inter-sectoral activities tackling the several causes underlying the prevailing poor health of children and mothers;

c. support for the development and implementation of a National Food and Nutrition Policy;

d. control of the growing problem of iodine deficiency disorders in 16 goitre endemic districts; and

e. reinforcement of the Government's Safe Motherhood Programme in three of the ten administrative regions.

Programme Objective

141. The principal objective of the Health and Nutrition Programme is to assist in the reduction of under five and maternal mortality attributable to the problems that it will address.[3]

a. The national objective of the integrated EPI/ORT intervention is to contribute to the reduction of child mortality attributable to EPI

[3] The general evolution of under five mortality will be strongly influenced by the AIDS epidemic and replacement mortality linked to, among other things, the socio-economic environment.

diseases (including neonatal tetanus) and to diarrhoea by 64 percent.[4] This cluster of diseases is presently responsible for one third of under five mortality.

b. In the ten districts selected for PHC development, the objectives are:
   i. to reduce under five mortality attributable to immunisable diseases, diarrhoea, ARI, malaria and malnutrition by 64 percent;[5]
   ii. to reduce the incidence of immunisable diseases by 70 percent;[6]
   iii. to reduce the prevalence of malnutrition (i.e., weight-for-age) from 58 percent to 30 percent;
   iv. to reduce the prevalence of anaemia among pregnant women by 50 percent;

c. In the 16 districts where iodine deficiency disorders are endemic, the objective is to reduce prevalence among pregnant women by 50 percent.[7]

Geographic Coverage and Target Population

142. The nationwide EPI/ORT intervention aims at reaching:

a. 75 percent of children under one year of age with full dose vaccination against all six EPI diseases every year;

b. 75 percent of pregnant women nationwide with three doses of TT by 1995;

c. 50 percent of children under five nationwide with ORT treatment against diarrhoeal dehydration annually.

---

[4] 80 percent coverage with 80 percent efficacy.

[5] 80 percent coverage with 80 percent.

[6] 80 percent coverage with 90 percent efficacy.

[7] The prevalence of goitre in the sixteen districts will be studied by mid-1991 at which time it will be possible to determine the level from which the 50 percent reduction will be determined.

143. In the ten districts selected for District PHC Development, the programme will seek to achieve the following:

a. 80 percent of pregnant women receive at least two pre-natal visits, including screening for risk factors, treatment of malaria and anaemia prophylaxis;

b. 80 percent of deliveries are assisted by trained attendants, either a mid-wife or a trained TBA;

c. 60 percent of mothers receive at least two post-natal visits, including education on child spacing methods;

d. 80 percent of women of child bearing age receive three doses of TT;

e. 80 percent of children under one year of age are fully vaccinated against all of the six EPI diseases every year;

f. 80 percent of children under five receive ORT in case of diarrhoea;

g. 60 percent of children under five with fever receive correct malaria treatment;

h. 60 percent of children under 5 with acute lower respiratory infections receive correct antibiotic therapy;

i. 60 percent of children under three are weighed at least quarterly, specific causes of faltering growth are identified (distinguishing between infection, feeding pattern, and food availability), and appropriate responses made.

Programme Strategy

144. The Programme strategy has four interlinked approaches:

a. Developing effectiveness in service delivery: The essence of the programme strategy is to consolidate and maintain the achievements of EPI/ORT country-wide while simultaneously starting to reach out to women and children with a broader and integrated package of health and nutrition interventions designed to make a quick difference in their health, particularly in the reduction of maternal and under five mortality.

b. Developing efficiency in service delivery: The experience gained with EPI and ORT will facilitate a progressive expansion in coverage through additional and integrated interventions such as pre-natal care, malaria and ARI treatment and growth monitoring. In order to provide more services in the context of limited resources, there is an urgent need to improve the cost effectiveness of service delivery, increasingly requiring a high degree of efficiency in the management of the health system through better resource allocation and management and community control to reduce wastage and leakage.

c. Ensuring sustainability of service: Even if more efficient management succeeds in minimising costs, additional resources will still be required to meet increasing needs. A cost-sharing approach involving the Government, the community and other sources needs to be established and operationalised. The community's readiness to contribute to the system will depend, to a large extent, on the ability of its members to control what they contribute and their perception that the required services are accessible and of a higher quality than previously.

d. Promoting health and development: Capacity building at community level, through community participation in health management, implies organising the health system in such a way that people learn how to manage health services and, gradually, other interventions such as income generation, food production and food processing.

145. These concepts, which have evolved from past and current experience in Ghana and are in concurrence with the Bamako Initiative, provide the basis for the following operational thrusts during the 1991-1995 Programme of Co-operation:

a. decentralised planning and management of integrated, effective and efficient community-based PHC services;

b. strengthened district and local level management capacity in planning, implementing and monitoring of the PHC system;

c. establishment and strengthening of cost sharing mechanisms under community control; and

d. provision of appropriate back-stopping on policy and management from national and regional levels.

Complementarity and Linkages with Other Programmes

146. The Health and Nutrition Programme encompasses most of the components of Primary Health Care and is closely linked with the other sectoral programmes proposed for the 1991-1995 period of collaboration. At the national level, the Annual Planning and Review Meetings will provide the forum for ensuring that the projects and activities of the Health and Nutrition Programme are supportive of and are supported by all other projects and activities within the Programme of Co-operation. In terms of management, the structure of Task Forces described under the District PHC Development Project will facilitate discussion among key Government counterparts at all levels and will identify gaps requiring greater co-ordination.

PROGRAMME BUDGET/TIME FRAME

(THOUSANDS OF US DOLLARS)

PROJECT/Activities	1991	1992	1993	1994	1995	TOTAL
HEALTH AND NUTRITION PROGRAMME						
1. Expanded Programme on Immunisation/ORT	1391	561	498	516	481	3446
2. District PHC Development	188	418	1100	1153	987	3846
3. Food and Nutrition Policy Development	15	22	15	10	0	62
4. Control of IDD	85	290	210	65	50	700
5. Support for Safe Motherhood Prog.	108	185	205	213	137	848
SUBTOTAL	1787	1476	2028	1957	1655	8902
Programme Support	183	126	117	137	127	690
TOTAL PROGRAMME	1970	1602	2145	2094	1782	9593
Funding.						
General Resources	643	748	876	850	961	4078
Funded Sup Funding	510	0	0	0	0	510
Unfunded Sup Funding	817	854	1269	1244	821	5004
TOTAL PROGRAMME	1970	1602	2145	2094	1782	9593

PROJECT: NATIONAL EXPANDED PROGRAMME OF IMMUNISATION/ ORAL REHYDRATION THERAPY

PROGRAMME SECTOR: HEALTH AND NUTRITION

IMPLEMENTING AND CO-OPERATING ORGANISATIONS:

PRINCIPAL COUNTERPART:	**MINISTRY OF HEALTH (MOH/EPID DIVISION)**
PRINCIPAL DONORS:	**UNICEF (CIDA, CPHA), USAID, WORLD BANK, ROTARY INTERNATIONAL**
PROJECT BUDGET:	**US$ 3,447,000**

OVERVIEW

147. Although immunisation coverage of children under one increased from 11 percent in 1985 to 50 percent in 1989 and is expected to reach 75 percent by December 1990, major efforts are still required to establish immunisation as a routine service covering a minimum of 80 percent of all children under one and all women of child-bearing age. Thus, out of the over 1,200 health institutions in the country[8], only 508 are currently delivering vaccination services and, of these, 475 do not provide vaccinations on a daily basis. By mid-1991, the Epidemiology Division will identify the basic reasons for this low participation and will devise a schedule and identify back-up requirements for incorporating all these institutions into the EPI programme.

148. Diarrhoeal diseases are among the most common childhood diseases in Ghana, with about 35 percent of children suffering episodes of moderate and severe diarrhoea each year. Efforts to control diarrhoeal diseases have intensified since 1986 with the use of ORS for case management in clinics and the revival of public education on the use of ORS sachets and home-made solutions. Local production of ORS beginning in 1988 has further enhanced on-going efforts.[9]

---

[8] Currently, 108 hospitals, 400 health centres/posts and at least 700 private medical practitioners and midwifery clinics provide MCH services in the country under the auspices of the Ministry of Health.

[9] The project involved the MOH and DANAFCO Pharmaceutical Ltd., with support from USAID and UNICEF. The participation of the private sector led to a six-fold increase in ORS distribution points.

149. According to the GDHS (1989), 43 percent of children suffering from severe diarrhoea were treated at health facilities while 33 percent were given pre-mixed ORS at home and six percent were given home-made solutions. The remaining 24 percent received traditional treatments. Although encouraging, these gains have not yet met all requirements: not all mothers are yet aware of the life-saving potential of ORT and health facilities still require support to ensure the continuing expansion of effective diarrhoeal case management using ORT.

150. Immunisation campaigns, through which 93 percent of children under one were reached in 1989 with BCG and DPT1, will be gradually replaced by routine static and outreach services. This step is crucial in order to reduce the high drop out rate (40-41 percent for DPT/OPV) and incorporate the promotion of ORT during vaccination services. This will necessitate a blend of the following:

a. the expansion of immunisation services to reach all women and children on a regular basis and the establishment of an effective planning and monitoring system;

b. the training and retraining of health staff, particularly at the grassroots level, to ensure a high standard of service delivery;

c. the timely provision and appropriate management of EPI and ORT supplies and equipment;

d. strengthening of the logistics support system to ensure availability of services at the periphery; and

e. the expansion of social mobilisation and advocacy efforts to foster high demand and support for utilisation of immunisation services and ORT nationally.

151. The Epidemiology Division of the Ministry of Health will be responsible for the management of the Project nationally and for co-ordination between collaborating agencies. In line with the Government's decentralisation policy, Regional Directors of Medical Services and District Health Management Teams will undertake the technical management and supervision of service delivery at sub-national levels.

PROJECT COVERAGE/TARGETS

152. The EPI component of the Project aims at providing immunisation to 80 percent of all children under one year of age (by antigen). In addition, it will provide 75 percent of pregnant women with three doses of tetanus toxoid vaccination.

153. The CDD component of the Project will promote ORT through staff involved with vaccination at all sites and sessions. It will seek to ensure that 80 percent of

the 2.7 million children under five in the country receive ORT as the treatment of choice for diarrhoea and that parents and potential parents become knowledgeable about the benefits and preparation of ORS.

PROJECT APPROACH

154. The central strategy for the EPI/ORT Project during 1991-1995 will be to expand routine immunisation service together with other basic health services, particularly the use of ORT. These services will be delivered:

a. daily in all public and private health institutions providing MCH services;

b. once a week in areas within an eight kilometre radius of all rural health centres/posts; and

c. at least once every two months in remote communities beyond an eight kilometre radius of a rural health centre/post.

155. This will involve increasing of access through:

a. the inclusion of at least 700 private health institutions into the mainstream of immunisation and ORT delivery, so as to enable them provide services on a daily basis;

b. the establishment of 1,600 rural outreach sites, 4 under each of the existing 400 health posts, for bi-monthly outreach service; and

c. the maintenance of extended outreach once every two months to communities beyond the regular outreach sites.

156. Effective service availability will be increased through:

a. training and retraining of health staff; and

b. strengthening of the logistics system to ensure timely provision of supplies and equipment to all delivery points.

157. Effective utilisation of services will be increased through social mobilisation and advocacy.

ACTIVITIES

Expansion of Regular Immunisation Services

158. By mid-1992, all 508 institutions currently delivering immunisation services will be supported to provide vaccination on a daily basis. Of these institutions, the 400 health centres/posts will be organised to conduct a minimum of 1,600 outreach sessions every month, in addition to providing daily service at each centre/post. In addition, all 700 private institutions not yet providing vaccination services will be incorporated into the mainstream of daily vaccination delivery by mid-1993 through mobilisation efforts and through the provision of vaccines to them.

159. The organisation of outreach services by all health centres/posts will be as follows:

a. By December 1991, District Health Management Teams, assisted by their respective Regional Directors of Medical Services and concerned Assemblymen, will complete the mapping of catchment areas eight kilometre radius of each health centre/post. As the mapping exercise for each health centre in each district is completed, the team will group the communities into four quadrants, each to be served by the health centre/post once a month at a specified site and day, and for which detailed logistics support and report formats will be designed and put in place, including community registers; and

b. With regard to communities falling outside the eight kilometre radius catchment area, the District Health Management Teams will devise strategies which will ensure that there is at least one outreach service every two months from one or two neighbouring health centres/posts.

160. Besides support for supplies, relevant equipment and training of staff, UNICEF will provide technical assistance and materials for mapping catchment areas and designing and installing an appropriate system for recording, reporting and monitoring vaccination and ORT operations in all outreach sites and health institutions.

Training

161. A series of training and refresher sessions will be conducted at national, regional and district levels. The training sessions and refreshers will be aimed to:

a. involve health staff not so far engaged in preventive care, that is, excluding MCH/FP and Medical Field Unit staff);

b. integrate other preventive health services, in the delivery of immunisation and ORT services; and

c. upgrade the managerial, supervisory and technical skills of health staff in all health institutions, including those in the private sector.

162. National level training will be aimed at 30 core regional staff, three from each region. These will, in turn, train approximately 330 district managers and supervisors. The 330 district core trainers, three per district, will then train approximately 50 enrolled nurses, clinical nurses, medical assistants and midwives in each of the 110 districts. The topics of the training will include essential aspects of micro-level planning, management and supervision of operations.

163. The training for district staff will focus more on details of injection techniques, site management and dropout control, diarrhoeal case management, recording and reporting, and delivery of health education messages. Continuous in-service training will be provided once every year during review meetings lasting three to four days at the district headquarters. The training of 20 regional and 110 district level cold chain technicians will be undertaken at the Epidemiology Division in 1992 and 1994.

164. WHO modules on EPI and CDD delivery and management will be modified by the Epidemiology Division to suit local needs and will be produced in approximately 2,000 sets for distribution to all health institutions. In collaboration with the Non-Formal Education and Basic Education Divisions of the Ministry of Education, relevant aspects of both EPI and CDD will also be incorporated in the development and production of teaching and learning materials aimed at functional literacy and primary school students and teachers.

165. To facilitate the delivery of training packages, UNICEF will support the development and production of training materials as well as assist with the daily allowance and transport costs of trainees.

Vaccinations

166. Based on requirements to be established by the Epidemiology Division, UNICEF will provide all the vaccines required in 1991, with the Ministry of Health taking over this responsibility as of 1992. For the period 1992-1995, UNICEF will provide 50 percent of required inoculation supplies (e.g., syringes, needles, and sterilisers) excluding vaccines, with the balance of required inoculation supplies being provided by the Government. The Government has already taken steps to gradually absorb these costs, and negotiations with the World Bank and the African Development Bank for the financing of vaccines, transport and portions of cold chain equipment are currently being finalised.

Vaccine Storage

167. In view of the expansion of immunisation services to replace campaigns, the Epidemiology Division will, by mid-1991, take stock of cold chain equipment available in the system, assess its compatibility and adequacy with regard to storage demands at regional, district and health centre/post levels, and establish requirements for replacing old units, as well as for equipping new centres. UNICEF will provide supplies towards the fulfillment of requirements in all the 45 newly created districts and 50 percent of requirements in the remaining 65 districts. Emphasis will be given, however, to the support of outreach services and the involvement of private medical practitioners and midwives. As with vaccines, the Ministry will absorb major cold chain requirements from 1992 onwards, with support from the World Bank.

Local Production of Oral Rehydration Salts (ORS)

168. UNICEF will continue to provide all the basic raw materials for the production of ORS. Approximately two million sachets of 600 ml each will be produced per annum, resulting in a total supply of 10 million ORS sachets for the 1991-1995 period.

Establishment of ORT Units

169. To support the training of medical staff in appropriate diarrhoeal case management, Diarrhoea Training Units (DTUs) will be established at the Korle-Bu and Komfo Anokye Teaching Hospitals. The DTUs will ensure proper treatment of acute diarrhoea in children as well as routine training of student medical doctors and clinical nurses.

170. In increasing and ensuring the availability of ORT and its accessibility for effective diarrhoeal case management, UNICEF will provide supplies and equipment (utensils for the preparation and administration of ORT, and locally produced furnishing benches and tables) necessary to set up ORT Units in all regional and district hospitals, representing a total of 108 institutions, between 1991 and 1992. In addition, ORT Units will be established in all 400 health centres/posts. The role the private sector can play in diarrhoeal case management and the type of support required for its involvement will be actively explored during 1991-1992.

Logistics Support

171. With support from the World Bank, UNFPA and UNICEF, the Ministry of Health has been assessing its transportation and logistics support requirements with a view to rationalising and standardising support for the district health system. An adequate number of vehicles (four-wheel drive and motorcycles) is also expected to be provided by the World Bank and other donors. UNICEF support in

this area will therefore be limited to specific localities where the assistance from other donors might not be forthcoming.

Social Mobilisation[10]

172. The aim will be to empower communities with information on the six preventable EPI diseases and on diarrhoeal dehydration by creating awareness of the interventions to be undertaken to safeguard their children. In collaboration with the National Social Mobilisation Committee for Child Survival and Development (SMCCSD) and the Health Education Division of the MOH, appropriate EPI communication materials for various target groups (including action-oriented leaflets and posters) and specific communication media targeted at communities and parents will be designed, produced and disseminated.

173. The CSD Unit of the Ghana Broadcasting Corporation, in conjunction with other collaborating agencies (MOH and donors), will develop specific programmes on radio and television. Additionally, a song on EPI/ORT will be developed and aired periodically on both radio and television. Radio and television adaptations of EPI-focused dramas will also be developed.

174. At the national level, the national SMCCSD will initiate actions for the utilisation of all Government structures for mobilisation in EPI/ORT, beginning with the vaccination of all government staff and their dependents by way of example. At the community level, the CSD structure will be supported in the dissemination of materials on CSD, including through distribution of the CSD quarterly newsletter containing information on EPI/ORT.

MONITORING AND EVALUATION

175. Information on vaccinations administered, ORS sachets used and diarrhoeal cases handled in the catchment area of each health centre/post will be compiled and analysed monthly both at the health centre/post and district headquarters. The analysis will include comparison of vaccinations administered to the eligible population targeted for the month, number of dropouts and reported cases of adverse reactions. Based on the reports from the health centres/posts, the district headquarters will take the necessary remedial action as well as compile and submit a consolidated monthly report to its regional headquarters. At the regional headquarters, a similar analysis will be conducted on district-level performance, remedial actions will be taken, and the region's performance compiled and a consolidated report sent to the Epidemiology Division every month.

[10] See the Social Mobilization Programme for a detailed description of the structure and functions of the Social Mobilization Committees for Child Survival and Development (SMCCSDs) at the national, regional, district and sub-district levels.

176. Every six months during, two to three day meetings will also be held at district, regional and national levels, to review quarterly performance. At the district, the District Medical Officer and two of his senior supervisors will conduct the review with relevant staff from health centres/posts and other health institutions. At the regional level, District Medical Officers, joined by their core trainers, will review the region's performance with the Regional Director of Health Services and the EPI/CDD Co-ordinators. Likewise, at the national level, three senior officials from each of the 10 Regional Health Administrations will meet with the Director of Medical Services and the head of the Epidemiology Division to assess national performance and develop corrective measures. At each level, these review meetings will also serve to reinforce and upgrade the skills and knowledge of health workers not only on EPI, but also on other preventive health measures.

177. Once each year, the office of the Regional Director of Health Services will conduct cluster surveys in the region to validate the monthly reports of districts. The results will also be matched with disease surveillance reports that will be compiled in at least three sentinel sites to be established in each district.

178. In co-ordination with the Evaluation Project (in the Planning, Monitoring and Evaluation Programme), two evaluations will be conducted during the programme period: the first in early 1991 as a follow-up to the review of 1989 and as a means of ascertaining the attainment of UCI 1990; and a second in 1994 to assess overall advances made in the promotion of PHC.

MANAGEMENT OF THE PROJECT

179. At the national level, the Epidemiology Division of the Ministry of Health will be responsible for the overall management of the Project and the procurement and distribution of supplies. The Regional Directors of Medical Services, assisted by their EPI/CDD Co-ordinators, will monitor the Project in their respective regions and provide the back-up support required by the districts. At the district-level, the District Medical Officer, assisted by members of the District Health Management Team and relevant NGOs, will manage and supervise local-level planning and implementation.

LINKAGES/CONVERGENCE

180. The EPI/ORT Project will reinforce and extend previous efforts to enhance PHC through UCI. The emphasis on the involvement of all health staff in preventive care, and in bringing preventive health services beyond the immediate surroundings of health posts to remote communities, will reinforce all other UNICEF interventions designed to enhance PHC. This will be particularly evident in the ten districts where UNICEF intervention focuses on building the capacity of both communities and District Health Management Teams to promote the convergence of basic services with the full involvement of communities.

181. Co-ordination at the national level between donors and other collaborating institutions will be the responsibility of the Epidemiology Division. The Regional Directors of Medical Services and District Medical Officers will co-ordinate activities at their respective levels.

GOVERNMENT CONTRIBUTIONS

182. The direct contribution of the Ministry of Health to the EPI/ORT Project during 1991-1995, in the form of salaries, equipment and supplies, will amount to approximately US$ 16 million (including contributions to the Government from other donors).

PROJECT INPUTS

183. UNICEF will support the cost of the following project inputs, to the extent available financing permits:

Inputs	1991	1992	1993	1994	1995	Total
EPI/ORT						
County registers/mapping materials (sets)	200	200				400
Production of training modules (sets)	2000					2000
Training/review sessions						
350 regl/district managers/Supervisors	11	11	11	11	11	55
6,000 health staff	180	210	240	240	240	1110
600 new recruits	0	25	26	27	27	105
1,400 from private institutions	18	18	18			54
130 cold chain technicians	11	11	11	11	11	55
Vaccines:						
DPT 10 dose vials ('000)	282					282
*OPV 10 dose vials ('000)	315					315
BCG 20 dose vials ('000)	74					74
Measles 10 dose vials ('000)	152					152
TT 20 dose vials ('000)	409					409
Sets of 200 0.5 ml and 100 0.1 ml reusable syringes, twice a year	420	435	405	405	405	2070
Sets of 20 pks of 22g and 10 pks of 26g needles, four times a year	420	435	405	405	405	2070
Sterilisers (units)	100	100	100	100	100	500
Cold chain equipment & parts in sets:						
- new dists: 1 fridge, 1 freezer, cold boxes, 20 vac. carriers.	15	15	15			45
- new health centres: 1 fridge, 1 cold cold box and 6 vac. carriers.	5	5	5	5	5	25
- Replacement sets:						
Regions: 2 ILRs, 2 freezer, 6 cold boxes, 1,000 ice packs.	2	2	2	2	2	10
Districts: 1 fridge, 1 freezer, 3 cold boxes, 20 vac carriers	11	11	11	11	11	55
Health centres: sets of 1 fridge, 1 cold box & 6 vac. carriers	20	40	40	40	40	180
ORS (in '000 sachets)	1750	1900	2100	2300	2550	10600
ORT units	56	254	200			510
UCI/ORS evaluation	1			1		2
four-wheel drive vehicles.	3	2	3	2	3	13

* NOTE: OPV to be supplied by Rotary International

PROJECT BUDGET

PROJECT/Activities	1991	1992	1993	1994	1995	TOTAL
Expanded Programme on Immunisation/ORT						
Expansion of services	92	40	0	0	0	132
Training	196	139	111	100	99	645
Vaccination	750	87	81	80	80	1078
Storage of vaccines	154	150	151	151	151	757
Local production of ORS	35	38	42	46	51	212
Establishment of ORT units	17	12	4	0	0	33
UCI/PHC evaluation	50	0	0	40	0	90
Logistics support	42	33	46	34	39	194
Communication/social mobilisation	55	62	63	65	61	306
PROJECT TOTAL	1391	561	498	516	481	3447
Funding.						
General Resources	199	248	167	138	282	1034
Funded Sup Funding	375	0	0	0	0	375
Unfunded Sup Funding	817	313	331	378	199	2038
PROJECT TOTAL	1391	561	498	516	481	3447

PROJECT: DISTRICT PHC DEVELOPMENT

PROGRAMME SECTOR: HEALTH AND NUTRITION

IMPLEMENTING AND CO-OPERATING ORGANISATIONS

PRINCIPAL COUNTERPARTS:	MOH AND MLG
PRINCIPAL DONORS:	UNICEF, UNDP, WHO and WORLD BANK
CO-OPERATING INSTITUTION:	NDPC AND MOA
PROJECT BUDGET:	US$ 3,846,000

SUMMARY

184. District PHC Development aims at providing an integrated package of interventions (Maternal and Child Health, EPI, ORT, ARI, malaria treatment and prevention, community nutrition, growth monitoring) that directly addresses the majority of preventable causes of child and maternal morbidity and mortality at the village level. The Project will initially focus on ten districts, one in each of the ten regions in the country, and will both emphasise the development of comprehensive, integrated and community-based activities, and establish entry points for other inter-sectoral and community development activities designed to address some of the root causes of health problems.

185. The Project has three inter-linked approaches:

a. establishment of decentralised planning and management of an integrated, effective, and efficient community-based PHC service;

b. strengthening of the capacity of District Health Management Teams (DHMTs) to guide and support community-based activities; and

c. support for regional and national health cadres to develop their capacity to guide and support the district teams.

BACKGROUND

186. In spite of the adoption of a PHC policy in 1978, its implementation has remained largely incomplete. The health system remains predominantly curative and centralised at hospitals and health centres, with only limited emphasis given to community-level facilities and outreach activities. As a result, PHC services do not reach 55 percent of the country's rural population. Even for those living within the

catchment area of the current health system, the supply of drugs is still unreliable and, when drugs are available, they are often beyond the financial means of the majority of those needing them. Quality of service also needs improvement.

187. The supply of drugs to communities, within the context of the Bamako Initiative, was launched in five districts, one in each of five regions, during 1989-1990. This project is aimed at empowering communities and linking them with district-level health system. The goal is to establish a mechanism by which communities can, in the short term, secure and administer their own drug requirements and, in the long term, develop the capacity for financing expanded PHC initiatives in the district. Based on the results of operations research conducted in all the five districts, guidelines for implementation are currently being established. Although beginning in only five districts, the Government has committed itself to expanding the scheme to the entire country once its feasibility and effectiveness have been demonstrated.

188. The recent introduction of the Government's "Cash-and-Carry" system of drug supply, which incorporates the existing policy of 100 percent retention of fees collected from patients, is aimed specifically at improving the availability of reliable drugs in Government health institutions. Although a significant step forward, the scheme does not yet go beyond health centres/posts and is, therefore, not directly supportive of community-based PHC. Once both the Bamako Initiative and the "Cash-and-Carry" schemes are fully functional, the availability of essential drugs at all levels of the health system should be significantly improved.

189. Although both the Government and UNICEF have made continuous efforts over the past decade to stimulate the development of PHC, a number of factors have so far hindered significant progress. Delays in the Government's planned decentralisation of administrative authority (including the creation of District Assemblies) has been one major constraining factor. A second factor has been the continued lack of resources at the district, regional and national levels, largely due to the economic difficulties of the 1970s and early 1980s and the consequent budgetary restrictions. Finally, and perhaps most importantly, the lack of appropriate orientation towards PHC on the part of health staff has led to the continuation of past practices and a preference for more traditional, centralised and curative approaches. At the district level, in particular, there is insufficient capacity to plan, implement and monitor PHC systems in accordance with the felt needs of communities.

GEOGRAPHIC COVERAGE AND TARGET POPULATION

190. The Project covers ten selected districts, one from each of the ten administrative regions of the country. The limited number of districts and their distribution among all ten regions results from various considerations, with the primary reasons being the merit of assisting each region to enhance its capacity,

through development of experience in one district in the region, and the potential quicker replication of positive experiences in other districts within each region. The criteria used in selecting the ten districts included, among others, their accessibility for regular monitoring and their relative needs. The five existing Bamako Initiative pilot districts, in which activities began in 1990, are included among the ten selected districts.

191. The ten districts selected for the Project have a total population of about one million. The target population in the ten districts is composed of:

a. 40,000 children under one annually;

b. 170,000 children between one and four years of age (total);

c. 223,000 women of child bearing age (total); and

d. 53,000 pregnant women annually.

PROJECT APPROACH

192. The Project is designed to begin from the perspective of the needs of the individual community, as it is at this level that maternal and child deaths actually occur. Through improved provision of services by village health workers and extension staff of sectoral ministries, and through the mobilization of community groups to help themselves, the project will help develop the necessary resources and pre-conditions for effective PHC in each village. At the same time, the Project will also seek to directly address the principal constraints which have so far hindered the effective implementation of PHC systems in Ghana. At the district level, the Project will provide support for improved training, supervision, management and monitoring for District Health Management Teams to enable them to adequately support community-based PHC initiatives. At the regional and national levels, support will be provided both for management and supervision and also in the key areas of advocacy and policy formulation. At the national level, the Deputy Director of Health Services currently provides overall guidance to local PHC development.

193. In order to address the issue of dispersion of resources and efforts, the Project will focus on a limited number of districts as noted above. In addition, interventions in these districts will be phased in gradually, in order to allow Government and UNICEF staff to concentrate on developing viable and replicable models before expanding to a larger number of districts. At the end of the five-year programme cycle, progress in the ten selected districts will be assessed with a view to replicating the system nationally in the 1996-2000 Programme of Co-operation. The implementation phasing for the period 1991-1995 will be as follows: two districts in 1991; three districts in 1992; and five districts in 1993. Similarly, within

each district efforts in the first year will focus on only one of the average five health institutions present in each district (one district hospital and four health centres). Once activities are underway at the first health institution, activities at a second and third institution will begin in the second year, and activities at the remaining two institutions will begin in the third year. In this way, projects in all five institutions in each of the ten districts will be fully underway by the fifth year of the Programme of Co-operation. The chart below shows the phasing of implementation:

PHASING OF PHC DISTRICTS AND REFERRAL CENTRES

Districts	Centres absorbed					
	1991	1992	1993	1994	1995	Total
Districts 1 and 2	2	4	4	0	0	10
Districts 3, 4 and 5	0	3	6	6	0	15
Districts 6,7,8,9 & 10	0	0	5	10	10	25
Annual total	2	7	15	16	10	50
Cumulative Total	2	9	24	40	50	

SUB-PROJECT 1: Integrated Community-Based PHC System

194. High rates of under five and maternal mortality prevail at the community on account of immunisable diseases, malaria, ARI, diarrhoea, and obstetrical problems, all of which are compounded by malnutrition. Interventions are either unavailable or inaccessible. Where available and accessible, services are provided on a piecemeal basis, with little or no synergistic effect on the complex web of problems facing the child and the mother. Community participation, where in existence, is often for compliance and facilitation of service providers rather than partnership in resolving problems.

195. The different levels of the district health delivery structure, the district hospital team, the health centre teams and the community health workers will be trained in drug management and drug accounting methods. The different levels of community responsibility, such as District Assembly representatives and Unit

Committee members, will be sensitised and trained to take up their participatory role in the management of the health system.

196. The Sub-Project therefore aims to develop a package of PHC services with the accompanying support system incorporating preventive and curative maternal and child health care, (EPI, diarrhoea, malaria, ARI, nutrition, growth monitoring) at the level of communities and health centres/posts. This will be ensured through the following activities:

Training/Capacity Building

197. Health centre/post staff and members of the management committee of the community will be provided with the technical and management skills they require to assess the community's situation, identify and prioritise needs, develop micro-plans, and manage and monitor implementation. The community's capacity to perform these tasks will be continuously upgraded through the monthly dialogues between health field staff and members of the Unit Committee. Basic to these dialogues will be the mutual recognition that it is indeed the community that is most responsible for mobilising and guiding its members to address its problems and that the role of health staff (and other field staff) is only to assist the community in the process.

198. For each of the 24 communities within the catchment area of a health centre/post, one community member identified by the community's health management committee will be trained and supplied with start-up ledgers and receipt pads to facilitate proper management of the revenue from the sale of drugs (and other services). In addition, the community's management team will be sensitised and assisted (by staff from the health centre) to ensure that:

a. the pricing of services, particularly of drugs, should enable the recovery of vital operating costs and provide a profit margin that will, to the extent possible, take account of subsidies to those who are unable to pay, inflation and changes in the exchange rate; and

b. give utmost priority to the regular availability of required drugs when allocating revenue.

Service Delivery

199. For each of about 1,200 communities, a team of one Community Clinical Attendant and one TBA will be trained and supplied with a bicycle, TBA kits, essential drugs and other start-up materials to enable them assist the community with better health care and operate under the close supervision of health centre staff. Trained TBAs will assist home deliveries and promote malaria and diarrhoeal

control as well as consult mothers on nutrition, sanitation, and child spacing and care, and provide timely advice on immunisations.

200. Trained Community Clinical Attendants will undertake regular home visits to identify and follow up risk cases such as malnourished children and pregnancies at risk, track immunisation drop outs to complete vaccinations, detect faltering child growth through regular growth monitoring as well as administer treatments for wounds and minor ailments, diarrhoeal dehydration, malaria and ARI. Besides mobilising the community for environmental sanitation and hygiene, Community Clinical Attendants (CCAs) will ensure that serious cases of pregnancies, malnutrition and ARI are referred to the health centre and followed-up adequately.

201. Health centre staff will also be trained and supported with materials and equipment to visit each of the 24 communities within their jurisdiction once a month and conduct monthly immunisation, screen risk factors, supervise and guide TBAs and CCAs and follow-up on risk cases. At the health centre, daily integrated care will be provided, ensuring that curative, pre- and post-natal care, as well as immunisation and growth monitoring are available to mothers and children seeking such services.

202. Community nutrition (encompassing community farming, weaning food storage and processing, and Vitamin A supplements) will be an integral component of the Project. In the ten selected districts, 50 communities, one from each Town/Area Council, will be selected for community nutrition activities, on the basis of district and community assessments to be carried out in 1991. The activities in each community will be managed by women's groups which will be trained in management and nutrition-related income generating activities such as food storage, food processing, milling, infant and child feeding practices and vegetable farming. Two mill operators per community will also be trained.

203. The management team members (about seven) of 50 Women's groups (one group per cluster of 12 communities or one Town/Area Council) will be trained in mill management and other nutrition-related income generating activities such as food storage, food preservation, and vegetable gardening. Each of the women's groups in the Town/Area Council will also be equipped with one grinding mill with prime mover (on a loan basis), and supported with other appropriate food processing, preservation and storage technologies as well as promoting improved household food security and some start-up cash registers and ledgers. A condition for the provision of the equipment and vegetable seeds will be that the women's groups will produce and promote weaning foods and vegetables, and that they support and maintain growth monitoring of children on a regular basis.

204. In the 50 sites where weaning food storage and production activities were initiated under the previous Programme of Co-operation (1986-1990), emphasis will be on training to strengthen the capacity of these communities to sustain weaning

food production and growth monitoring. UNICEF will phase out its assistance to these communities by the end of 1991.

Community Mobilisation and Empowerment

205. Person-to-person communication will be maximised to develop awareness on problems and mobilise support for actions. The routine dialogue between the community's management team and health staff on priority problems and appropriate actions will provide the forum to gain consensus on problems to be addressed and actions desired for stimulating change in attitude, behavior and practice. Dramas (which serve as the most common means of recreation for villagers) will be used to highlight critical concerns to their audience. The conscientisation and involvement of primary school pupils, teachers and Parent Teacher Associations as well as village branches of the Committee for the Defence of the Revolution, 31st December Women's Movement, and other economic and traditional social groupings in the community, will augment the dissemination of messages. Functional literacy classes (under the Non-Formal Education Project) will be built around key messages and desired actions. Social Mobilisation Committees for CSD at the district and Unit Committee levels will play a central role in mobilising and empowering community members (see the Social Mobilisation Programme for more details).

Sub-Project Inputs

206. UNICEF will support the cost of the following project inputs, to the extent available financing permits:

Inputs	1991	1992	1993	1994	1995	Total
Integrated Community-Based PHC System						
Starting centres	2	7	15	16	10	50
Functioning centres	2	9	24	40	50	
21-day training sessions for:						
- Health Centre staff (7/centre)	10	35	75	80	50	250
- Com. clinical attendants (24/centre)	10	35	75	80	50	250
- TBAs (24/centre - in 4 rounds)	10	35	75	80	50	250
- Unit Committee members (24/centre)	240	168	360	384	240	1392
Quarterly planning and review sessions (HC staff, CCAs & TBAs)	40	180	480	800	1000	2500
MCH booklets in '000s	48	168	360	384	240	1200
Ante-natal and child cards ('000)	25	18	38	40	25	145
Set of 5 registers	49	169	361	385	241	1205
Set of 5 receipt pads and 2 ledgers	48	168	360	384	240	1200
Essential drug kits: Community quarterly	192	864	2304	3648	3744	10752
Health center quarterly	40	180	480	760	780	2240
TBA kits	48	168	360	384	240	1200
Set of MCH kits, weighing scales, lab equipment, steriliser & maternity beds	48	168	360	384	240	1200
Injection equipment types A & B, 4 times	16	72	192	320	400	1000
Set of grinding mill and generator	8	28	60	64	40	200
Weighing scale for infants	48	168	360	384	240	1200
Package of vegetable seeds	8	36	96	160	200	500
Bicycles	48	168	360	384	240	1200
Set of typewriter filing cabinet	2	7	15	16	10	50

SUB-PROJECT 2: District Management Support for PHC

207. At present, District Health Management Teams do not have adequate capacity to plan, programme and monitor the implementation of an integrated PHC system at health centres/posts and at the community level. The existing support system is weak. Staff and community members trained for the periphery are often left to themselves without much follow-up and supervision. Equipment and materials available at the district are not always made accessible to the periphery due to weak logistics; and those that are made accessible quickly run out of order. Basic skills for adequate resource management and community involvement are lacking, essentially because of the predominantly clinical orientation of health staff.

208. The Sub-Project therefore aims to ensure that capacity is developed and strengthened at the district level to guide and support community-based PHC activities by :

a. undertaking and/or co-ordinating relevant studies and assessments to identify operational needs including training needs of staff and community representatives;

b. developing efficient micro-plans and implementation support systems, monitoring implementation and taking timely corrective actions;

c. training and retraining health staff and community counterparts to regularly upgrade their management and technical skills; and

d. mobilising required resources and ensuring their efficient distribution, especially drugs, and management.

Development of Micro-Plans and Support Systems

209. As the first step in the implementation of the Sub-Project, the five members of the District Health Management Teams (the District Medical Officer and four health staff) will be given a 21-day introductory course at national Headquarters on the management and technical skills required to launch the Sub-Project in their respective districts. The topics will include: relevance and methods for community involvement, micro-planning techniques and management, monitoring, practical information systems and the basics of costing, budgeting, pricing, programming, supervision and training techniques.

210. Immediately following this introductory training, the DHMT will be supported with material inputs and technical advise to analyse the situation in the district and synthesise relevant facts essential for the development of micro-plans and supporting systems relevant to each district. Based on regular operational research and the use of one health institution in each district as a "sentinel site", the micro-plans will be adjusted. The support system aims at facilitating the delivery and management of PHC in the whole district. It will involve the review of procedures, including forms and records, for determining minimum and maximum stock levels of materials, ordering and replenishment, storage, distribution and documentation of utilisation as well as for documentation and management of health data.

Monitoring and Supervision

211. Regular visits of district staff to health centres, and along with health centre staff to communities, will be established and supported to supervise operations, generate rapid response to problems as well as develop confidence and partnership among staff and community officials. The key to this will be the definition of what to look for and the regular use of checklists appropriate for district and health centre staff as well as for home visits of Community Clinical Attendants and, whenever possible, for literate TBAs. An important aspect will be the recording of observations and actions taken, for compilation and use in training and review

sessions. Regularity of visits on specified days, particularly by health centre staff to communities, will be rigorously complied with.

Resource Management and Mobilisation

212. In order to ensure a fair division of costs among the Government, communities and donors, the responsibilities of each will be clearly defined, and the management and control of the community's contribution left to the community itself.

213. An important measure to ensure the most efficient use of drugs will be the standardisation of procedures for diagnosis and treatment, both at community and at health centre. The establishment of appropriate storage facilities and a "transparent" information and control system that will facilitate cross checks between quantities of drugs used, the number of patients treated, and the money received and deposited will, it is hoped, minimise "leakages" and make the whole process amenable to timely corrective actions.

Advocacy and Social Mobilisation

214. The underlying theme will be that the needs of the community, and more specifically of its members, cannot be divided among the many agencies and their field staff and that services aimed at helping the community should be co-ordinated to the maximum extent possible, both at the district and at the community level, to have a unified impact on the multiple needs of the child. In this respect, the Unit Committee will be promoted as the sole co-ordinator of socio-economic development for each community, thus ensuring that projects implemented at the community level by one agency are co-ordinated with the those of all other agencies. Members of the District Assembly elected from the initial project communities will be assisted to pursue this theme in the Social Sector Sub-Committee of the District Assembly and mobilise the support of all agencies to co-ordinate their programmes. To nurture this co-ordination, periodic reports on accomplishments and constraints will be produced and distributed to all agencies represented at the district.

Sub-Project Inputs

215. UNICEF will support the cost of the following project inputs, to the extent available financing permits:

Inputs	1991	1992	1993	1994	1995	Total
District Management Support for PHC						
21-day training sessions for:						
- 50 district & regional managers	1	1	1	0	0	3
- 50 OR interviewers	1	1	1	0	0	3
- 50 Com. Devlpmt staff on management of income generating activities	1	1	1	0	0	3 0
Operation research	2	3	5	10	0	20
Quarterly review sessions	8	20	40	40	40	148
Vehicles (4-wheel-drive)	2	3	3	0	0	8
Micro computers and software	2	3	5	0	0	10
Sentinel surveillance support	2	3	5	0	0	10

SUB-PROJECT 3: Policy and Management Support for PHC

216. The ability of the districts to perform efficiently will depend on the capability of their regional and, in turn, national management teams to:

a. develop and/or adapt supportive policy guidelines;

b. provide timely and adequate logistics support with regard to the procurement and distribution of supplies;

c. ensure adequate staffing, budget approval and timely release of approved allocations;

d. provide support in monitoring and evaluation and assist with the design of required improvements;

e. mobilise multi-sectoral (including political) support from regional and national levels;

f. facilitate experience exchange both from within the country and externally; and

g. help in the design and provision of an integrated package of materials for the training of district and health centre staff as well as community members.

217. Health managers from both the regional and national levels will be supported to develop their own managerial and technical capabilities to provide the backing required by the districts. This will be addressed by the following activities:

Training/Capacity Building

218. At the beginning of each year during 1991-1993, the office of the MOH Director of Medical Services will organise and conduct a 21-day course for senior officers from the districts and regions that are to be absorbed by the Project during each of the three years. The aim will be to equip the officers with the managerial and technical skills which they will require for PHC development in their respective localities. The topics to be handled will include micro-planning techniques and management, relevance and methods for community involvement, costing, budgeting, pricing, monitoring indicators, programming, supervision, training techniques and practical information systems. It is envisaged that with this training, health managers will be able to prepare for launching the Project in their respective districts. The required refresher will be provided during the half-yearly reviews that will be conducted at the regional level. This will also be reinforced through exchange visits and conferences at inter-regional and international levels. Arrangements will be made for a team of three members from district, regional and national levels to attend PHC conferences and/or visit projects in other countries.

Planning and Monitoring

219. In order to ensure realism in the design of district plans, implementation steps, and relevant monitoring and evaluation indicators, a team of four researchers drawn from the national, regional and district management teams and an advisor will be supported to conduct detailed assessments of the districts. The subjects to be covered will include the existing coverage and quality of services, health care practices and support systems as well as the social and economic conditions prevailing in the districts.

220. The first two of these studies will be conducted during 1991. Based on the findings, the initial plans of action and the supporting management and information systems will be designed jointly by the national, regional and district teams for which the services of a consultant will be made available. Support will also be given to national and regional teams to assist the districts in the implementation of the plans and support systems. This will be accomplished through monthly field visits and half-yearly reviews of progress and constraints at national level. It is envisaged that this will contribute to the refinement of guidelines and the provision of required back-up in terms of, for example, resources and staffing from the national level.

Advocacy and Social Mobilisation

221. As the national and regional teams become conversant with the requirements of a system for the integrated delivery of services at the community level, they will be in a position to identify which services need to be closely co-ordinated both at the national and local levels in order to enable district branches (and field staff) of different sectors to link their operations at the community level. The national level PHC Task Force will provide the forum for mobilising the necessary political support. The production and distribution of periodic reports on achievements and constraints will be supported to promote this objective among the relevant sectors, including political and administrative organs at the national, regional and district levels.

Sub-Project Inputs

222. UNICEF will support the cost of the following project inputs, to the extent available financing permits:

Inputs	1991	1992	1993	1994	1995	Total
Policy & Management Support for PHC						
21-day training sessions for 20 regional and 5 national HQ managers	1	1	1	0	0	3
Half-yearly Task Force reviews	2	2	2	2	2	10
Quarterly regional review sessions	8	20	40	40	40	148
Experience exchange visits*	1	1	1	1	1	5
Four-wheel drive vehicles	2	3	5	0	0	10

Future Expansion of Activities

223. Ghana offers favourable conditions for successful implementation of district PHC strengthening namely, a high level of commitment to decentralization, the full responsibility of the District Assembly for development activities in the districts, the legal framework which is in place for financing health care, the political convergence of donor support at the district level, to the district and the commitment, skills and enthusiasm of the district health workers.

224. Considering the present needs of the districts, in terms of the accessibility and quality of available health care, the supply of drugs and management capacity of the DHMTs vis-a-vis the prevailing conditions of high levels of morbidity and mortality of mainly preventable diseases, there will be an urgent need to expand the project activities to other districts in the light of the experience which will be gained in the initial areas. The speed of expansion, however, depends on several crucial issues, such as the acceleration of the nationwide decentralization process,

finalization of the re-organization of the MOH, the training capacity of the MOH, development of successful mechanisms for community involvement and the availability of funds.

MANAGEMENT OF THE PROJECT

225. The MOH will have the central responsibility for the management of the Project from national to district levels. The office of the Director of Medical Services will co-ordinate implementation nationally. At the regional and district levels, the Regional Directors of Medical Services and the District Medical Officers, assisted by the District Health Management Teams (DHMT) and relevant NGOs, will have responsibility. At the community level, the Unit Committees will take full charge for planning, implementation and monitoring the Project (see paragraph 111 for a full description of the structure and role of the Unit Committees).

226. The Project will be monitored by a PHC Steering Committee, chaired by the PNDC Secretary for Health or designate, which will meet every six months for the duration of the Project. The Secretary, key national staff, the Regional Secretaries, the Regional Directors of Medical Services and the District Secretaries and District Medical Officers of participating districts will meet to discuss progress and to identify constraints to the full realisation of PHC in each of the targeted districts. The Steering Committee will convene in a different district each time it meets, thus giving top level leadership of the MOH the chance to see the situation at first hand. The participation of Regional and District Secretaries and health officials will be phased in together with absorption of their districts into the Project. The participation of the top-level political leadership of the MOH is viewed as essential in overcoming the constraints experienced to date in implementing PHC at the district level.

227. The Project will be supported through involvement of the Operations Research Department of the MOH. Areas of study will include alternative ways of co-financing activities within the Ghanaian context, different methods of strengthening community involvement in management of health services at the district and sub-district level, and identifying strategies to provide for the indigent and promote equity of services.

MONITORING

228. Monitoring will focus on the availability, access and quality of services to all children and women in target communities. Major indicators will be: the number and spread of home visits made and supervision conducted; the nature, size and trend of recurrent costs and revenue generated; and the number of initiatives undertaken by the community in relation to other components of PHC as well as food and nutrition health. Information on these indicators will be available from:

a. home-based records such as MCH booklets;

b. service-based sources such as treatment, financial, drug registers; and

c. special operations research studies on reasons for non utilisation of services, health care expenditure by socio-economic groupings, capacity and willingness to pay.

229. An initial operations research study was carried out in 1990 to provide baseline data for the implementation of the Bamako Initiative in the five selected districts. This study, "Baseline Survey for the Implementation of the Bamako Initiative in Ghana" has been published as a Bamako Initiative technical report. The principal conclusions of the survey were that:

- The implementation of PHC at community level has been constrained by a number of factors, including limited management support and a lack of mechanisms for community involvement.

- Health facilities are accessible to the majority of the population surveyed. 60 per cent of the sample indicated that they would attend a hospital or clinic as the first choice of care, based on factors of proximity, type of illness and the types of services available. Cost did not appear to be a barrier to choice of facility.

- The great majority of clients interviewed at drug outlets (85 per cent) found drug costs to be affordable. Organization of drug supply and storage were better in public than in private facilities. Some 15 per cent of the value of daily drug sales was consumed by staff, exempts and indigents.

- There was evidence of inappropriate use of drugs, and of shortages particularly of the drugs most commonly prescribed.

The study's conclusions stressed the need for strengthening managerial capacity at the local level, improved means to identify those too poor to pay, and measures to promote the rational use of drugs.

CO-ORDINATION AND LINKAGES WITH OTHER PARTNERS

230. All other projects of the 1991-1995 Programme of Co-operation between the Government of Ghana and UNICEF will reinforce the implementation of the PHC Project in the ten selected districts. Activities of the other supported departments at the district level (water and sanitation, education, social mobilisation) and inputs from other partners, Secretary, supported by the Social Sector Sub-Committee of the District Assembly. The District Health Management Team will play a prominent role in the day-to-day management of the project. This process will prevent

duplication of efforts and resources, and enhance the capacity building at the district level. Co-ordination with other collaborators in the ten districts will be ensured by the District Medical Officer, supported by the Social Sector Sub-Committee of the District Assembly. In addition, WHO is currently assisting the MOH in upgrading the management capability of the DHMTs through three rounds of management training workshops in each region, and each DHMT subsequently conducts three rounds of training in each district to actually put into practice the new management techniques. Active co-operation with WHO staff will be established to strengthen the development of PHC systems in ten district through the project. Building of capacity for support at the regional level will facilitate adoption of successful approaches on a wider scale. Specific areas of co-operation with WHO include EPI/CDD, district health management training, essential drug policy and rational use of drugs, ARI, AIDS, and maternal and child health.

231. The African Development Bank and the World Bank in the second Health and Population Project aim to bring about a progressive improvement in the quality and coverage of health services, especially for PHC. Components of the project include drug and vaccine supplies and drug infrastructure rehabilitation, provision and maintenance of district hospital equipment, and management of PHC services. Further co-operation is also expected in operations research concerning the many issues in PHC implementation. Linkages will be established with WHO staff to strengthen the development of PHC systems in the ten districts through the Project and to help ensure replication of successful approaches.

232. Co-operation between UNICEF and the Canadian assistance (CIDA) is well established in Ghana. At the national level, the EPI/CDD project has been supported by CIDA since 1987, and now with the shifting focus to an integrated approach at the district level, final arrangements are being made to continue this relationship during the new Programme of Co-operation.

GOVERNMENT CONTRIBUTION

233. The Government will support each of the sub-projects with approximate contributions as follows:

a.	Integrated Community-Based PHC System	=	US$ 2,200,000
b.	District Management Support for PHC	=	US$ 550,000
c.	Policy and Management Support for PHC	=	US$ 150,000
	PROJECT TOTAL		US$ 2,900,000

PROJECT BUDGET

(THOUSANDS OF US DOLLARS)

PROJECT/Activities	1991	1992	1993	1994	1995	TOTAL
2. District PHC Development						
Integrated community based-PHC system	80	193	717	926	836	2752
District management support for PHC	83	153	265	108	108	717
Policy and management support for PHC	25	72	118	119	43	377
PROJECT TOTAL	188	418	1100	1153	987	3971
Funding.						
General Resources	53	184	425	432	440	1534
Funded Sup Funding	135	0	0	0	0	135
Unfunded Sup Funding	0	234	675	721	547	2177
PROJECT TOTAL	188	418	1100	1153	987	3846

PROJECT: FOOD AND NUTRITION POLICY DEVELOPMENT

PROGRAMME SECTOR: HEALTH AND NUTRITION

IMPLEMENTING AND CO-OPERATING ORGANISATIONS:

PRINCIPAL COUNTERPART:	**MOH/NUTRITION DIVISION**
PRINCIPAL DONOR:	**UNICEF**
COLLABORATING AGENCIES:	**MOA**
PROJECT BUDGET:	**US$ 62,000**

OVERVIEW

234. The absence of a National Food and Nutrition Policy (FNP) continues to be a constraining factor in addressing nutritional problems in the country. A draft FNP prepared in 1984 is available for review, reformulation and adoption. The problem appears to have been the lack of leadership in carrying through the necessary review/reformulation,and in ensuring its adoption as Government policy.

235. In order to address this institutional problem, a new project has been formulated, within the 1991-1995 Programme of Co-operation specifically for the purpose of refining and promoting the formalisation of the National Food and Nutrition Policy. The Ministries of Health (Nutrition Division) and Agriculture will play the leading role in this project, and the Ministry of Finance and Economic Planning will co-ordinate the Policy Formulation Task Force to be created through the Project. Other collaborating agencies will include the Ministry of Local Government (MLG), Ministry of Education (MOE), National Statistical Service, National Council on Women and Development (NCWD), Ministry of Mobilisation and Social Welfare (Ghana National Commission on Children -- GNCC), Ghana Water and Sewerage Corporation (GWSC), Ghana Standards Board, the Food Research Institute (FRI), the three Universities, and the Ministry of Information (Information Services Department).

PROJECT COVERAGE

236. The promulgation of a new Food and Nutrition Policy will enable co-ordination of efforts by the Government and donors to help alleviate the nutritional problems of all women and children in Ghana.

PROJECT APPROACH

237. Taking the existing 1984 draft Food and Nutrition Policy, the Project will undertake high level seminars involving the sectoral ministries, Government

institutions, NGOs and donors to advocate for revisions to, and adoption of, a new Food and Nutrition Policy.

ACTIVITIES

National Food and Nutrition Policy (FNP) Formulation

238. The PNDC member for the Social Sector and the PNDC Secretaries for Health and Agriculture will convene meetings of a Policy Formulation Task Force comprised of Ministers, directors of departments and other relevant officials to sensitise them to the need for an FNP. It is expected that the Ministry of Finance and Economic Planning, as the institution responsible for overall policy development, will chair the meetings.

239. A smaller sub-committee, composed of five to eight members of the Task Force, will then review and, if necessary, reformulate the draft FNP. The Nutrition Division of MOH will hold a workshop for the members of the working group to update their knowledge concerning the latest statistics on nutrition in Ghana. The working group will then draw up a schedule of further meetings and workshops to take place between May and October 1991 for the purpose of completing the revision of the draft FNP. At the conclusion of its work, the working group will submit its revised draft both to the Task Force and to the National Food and Nutrition Co-ordinating Committee (NFNCC), a group of Government agencies, NGOs and donors who co-ordinate nutrition activities in the country. A meeting of the whole Task Force will be convened again in October/November 1991 for the purpose of reviewing and finalising the draft FNP.

240. UNICEF inputs will include the provision of technical assistance and support for stationery, transport (for regional participation in workshops), subsistence, and other costs related to workshops and seminars.

Legislation and Implementation of the FNP

241. Once finalised (by mid-1992), the revised draft FNP will be officially submitted by the Task Force to the Attorney General's Office for legal consideration. Legal and administrative procedures to establish adequate mechanisms for co-ordination will be prepared for approval between January and June 1993 by MFEP. These will include administrative procedures for the operation of the NFNCC. The new NFNCC will then be inaugurated in December 1993 and will work with a 22 member co-ordinating committee within the MFEP (including two representatives from each region and two from the national level). In 1994, Regional Food and Nutrition Co-ordinating Committees (RFNCC) will be established by each regional administration and a training seminar for these groups will be organised in December 1994 to evaluate progress. Prior to these seminars, 400 copies of the new FNP and 400

copies of the law and administrative procedures will be produced and distributed with UNICEF assistance.

242. In 1994, two workshops for Technical Heads (directors) of national ministries, departments and NGOs will be organised by the Nutrition Division of MOH. The purpose of these workshops will be to discuss mechanisms for actual implementation and monitoring the new FNP. UNICEF inputs will include support for stationery and other costs related to the workshops.

MONITORING

243. Progress will be monitored through regular participation by UNICEF staff in the various policy formulation meetings. In addition, the Annual Planning and Review Meeting, to be held each year, will assess performance based on the Annual Plan of Action. The Mid-Term Review planned for mid-1993 will serve as a critical check-point, as the final draft of the FNP should have been completed by that date.

MANAGEMENT OF THE PROJECT

244. The MFEP will co-ordinate the overall project, particularly the work of the Task Force, in consultation with MOH and MOA. The NFNCC, with the participation of UNICEF, WHO and FAO will review the draft policy and the Attorney General's Office will provide the necessary legal and analytical framework.

COLLABORATION WITH OTHER PARTNERS

245. The Project will be implemented in close collaboration with the Ministries of Agriculture, Health, Finance and Economic Planning and with WHO, the World Bank, WFP, FAO and other multi-lateral and bi-lateral donors participating in the NFNCC.

LINKAGES AND CONVERGENCE

246. The establishment of an effective Food and Nutrition Policy is expected to have significant benefits for all women and children and will therefore reinforce the efforts of all other programmes and projects to improve the health and welfare of these groups. The Project will draw directly on the information gathered through the growth monitoring activities to be undertaken through the District PHC Development Project and on data from the National Nutrition Survey (under the Planning, Monitoring and Evaluation Programme).

CONSTRAINTS AND OPPORTUNITIES

247. The lack of efficient inter-ministerial mechanisms for co-operation is the single greatest constraint that must be overcome. The existence of a draft FNP dating

from 1984 provides a firm basis for the efforts of the current project, however the successful sensitisation of PNDC Secretaries will also be critical to the success of this project. In this regard, the Technical Heads (directors) of the MOH and MOA (Policy Planning, Monitoring and Evaluation Units) will be instrumental in advising the PNDC Secretaries of the two major ministries to support the development of an FNP and, subsequently, to work jointly towards its implementation. The PNDC Member for the Social Sector will also play an active role in backing up the efforts of these two ministries.

PROJECT BUDGET

(THOUSANDS OF US DOLLARS)

PROJECT/Activities	1991	1992	1993	1994	1995	TOTAL
3. Food and Nutrition Policy Develop						
Policy formulation	15	10	10	0	0	35
Legislation and implementation	0	12	5	10	0	27
PROJECT TOTAL	15	22	15	10	0	62
Funding. .						
General Resources	15	22	15	10	0	62
Funded Sup Funding	0	0	0	0	0	0
Unfunded Sup Funding	0	0	0	0	0	0
PROJECT TOTAL	15	22	15	10	0	62

PROJECT: IODINE DEFICIENCY DISORDERS (IDD) CONTROL

PROGRAMME SECTOR : HEALTH AND NUTRITION

IMPLEMENTING AND CO-OPERATING ORGANISATIONS:

PRINCIPAL COUNTERPART:	**MOH**
PRINCIPAL DONOR:	**UNICEF**
COLLABORATING AGENCIES:	**UNIVERSITY OF GHANA**
PROJECT BUDGET:	**US$ 700,000**

OVERVIEW

248. Information on IDD in Ghana is extremely limited. Cases have, however, been reported in 16 districts in six regions indicating a spectrum of disorders caused by hypothyroidism. The northern sector seems to be the worst affected part of the country and an estimated population of approximately 2,600,000 are considered to be at risk. The serious effect of IDD on growth and mental development and the grave physical disabilities and social handicaps of neurologically affected persons make it imperative that control measures be accorded high priority. The interventions proposed in this project are preventive in nature, cost effective, simple and can be easily integrated into the Primary Health Care System. The lead implementing agency will be the Ministry of Health (Nutrition Division), collaborating with the Department of Nutrition and Food Science at the University of Ghana.

COVERAGE/TARGETS

249. Sixteen districts in the country with an estimated population of 2,600,000 are considered at risk. Of these, the Project will provide supplements or other services for an estimated 779,220 children aged 5-15 and 532,740 women aged 15-40, or a total population of 1,311,960.

PROJECT APPROACH

250. The main focus of the Project will be on the collection and analysis of information regarding the prevalence of IDD and, to this end, two iodine determination laboratories will be established. Iodised oil injections and capsules will be provided for at-risk populations, technicians will be trained in both data collection and administration of iodised oil, and materials will be developed to help sensitise health workers, parents and communities regarding the critical importance of controlling iodine deficiencies in order to reduce the incidence of goitre and cretinism. In addition, the Project will undertake the iodisation of drinking water on a trial basis and will explore the possibility of establishing iodisation of salt.

ACTIVITIES

Data Collection and Analysis

251. An epidemiological survey will be conducted by a research team constituted by the Ministry of Health (Nutrition Division), the University of Ghana (Department of Nutrition and Food Science), and the health laboratory services, in the second half of 1990 and throughout 1991. A market survey to determine the sources and distribution of salt in Ghana will be conducted by the research team in 1991 in conjunction with the Ghana Food Distribution Corporation and the Ministry of Trade. KAP studies on IDD will be conducted to identify information gaps to be addressed through the Information Education and Communication (IE&C) strategy (see paragraph 271, below). UNICEF inputs will include support for stationery, transport, subsistence and other costs related to report preparation. Workshops on the results of the surveys/studies will be organised by the Nutrition Division at national, regional and district levels. UNICEF will provide stationery and will support other costs related to the workshops.

Administration of Iodised Oil/Capsules:

252. Iodised oil injections/capsules will be given to children 5-15 years and women of child-bearing age in areas with high endemicity. UNICEF inputs will include iodised oil already purchased and available in the country, iodised capsules to be ordered from overseas and subsistence and transport to support the administration of iodised oil injections and capsules.

Development of Information, Education and Communication Strategy (IE&C)

253. In conjunction with the Social Mobilisation Programme (chapter on Social Mobilisation), this activity will sensitise health professionals, politicians, policy and decision makers and the general public on the following:

a. The prevalence of IDD in the country;

b. The consequences of IDD; and

c. Prevention and control measures.

254. There are information gaps to be filled even among health professionals, especially regarding the social significance of IDD. In order to bridge the gaps, a communications consultant will assist the Nutrition Division and a reputable advertising agency enlisted to draw up a creative publicity campaign and develop materials such as videotapes, hand bills, pamphlets and posters, which will be pre-tested and subsequently revised for large-scale production. To ensure full

coverage, health and non-health workers will be trained in the use of the materials developed.

255. In order to ensure continuous awareness creation, a National Committee for the Control of IDD (NCCIDD) will be constituted from the existing NFNCC to also include the three Universities, will be launched in 1992, after advocacy for IDD through the media and achievement of the necessary political support.

Iodisation of Water

256. Iodisation of water, using droplets of potassium iodide mixed with specified quantities of drinking water in the home, and the immersion of a silicon polymer containing iodine in boreholes, will be the two methods utilised in this activity. The first method of iodisation is cost-effective and very simple to implement. There is, however, a possibility that women may forget to add droplets to the drinking water. With strong educational backing and effective monitoring, however, this problem should be overcome. This method has been successfully tried in Thailand and could be implemented in communities without boreholes. The second method using the silicon polymer needs to be repeated every two years and requires regular maintenance of the boreholes. The canister containing the silicon polymer will release steady quantities of iodine into the water over a period of between 18-24 months. This method requires training of technicians and the dismantling of existing boreholes to introduce the silicon polymer.

257. With the assistance of Ghana Water and Sewerage Corporation, and the French company Rhone Poulene, which manufactures the polymer, ten boreholes will initially be iodised in 1991-1992 and, if successful, Supplementary Funds will be used to iodise a further 100 boreholes in the endemic areas in 1993-1995. Links will be strengthened with the community members responsible for maintenance of these boreholes in order to ensure continuous operation.

258. In co-operation with the Ministry of Trade and the Ghana Food Marketing Corporation, a study will be undertaken to assess the feasibility of using salt iodisation as a method of introducing iodine into the diets of the entire population. Depending on the results of this study, the Government and UNICEF may explore the possibility of initiating a more substantial project in this area.

Establishment of Iodine Determination Laboratories

259. Two laboratories with test-kits for iodine determination, one in Accra and the other in the northern sector, will work closely with the Public Health Laboratory. They will be serviced by technicians trained to analyze iodine levels in the urine of project beneficiaries given iodised oil capsules or injections.

Training and Workshops

260. Ministry of Health personnel will be trained to acquire skills in the following areas:

a. IDD survey techniques;

b. Estimation of iodine levels in both drinking water and beneficiaries' urine;

c. Administration of iodised oil; and

d. Programme Management.

261. Training will be done both locally and externally.

Social Mobilisation

262. In conjunction with the Social Mobilisation Programme, this activity will sensitise health professionals, politicians, policy-makers and the general public on the risks of IDD, especially cretinism, and the preventive steps that are necessary. Televised video documentation will be used to sensitise policy makers and health professionals about the dangers of IDD and, through the activities of the SMCCSDs, those at risk will be mobilised to make full use of the services (iodised oil injections and capsules) as they are provided.

MONITORING

263. The Project will be monitored through periodic visits and analysis of the following indicators by district level staff of MOH:

a. The number of iodised oil capsules distributed;

b. Number of the target population who receive iodised oil injections/capsules;

c. Observable changes in the effects/incidence of goitre; and

d. Urinary levels of iodine as determined by national laboratories.

264. Project implementation will be assessed each year during the Annual Planning and Review Meeting, with a more thorough analysis taking place during the Mid-Term Review in 1993, when the Project may be re-oriented, if necessary. Indicators to be monitored in the medium-term will include the number of iodised boreholes and levels of iodine in water from treated boreholes and in beneficiaries' urine.

MANAGEMENT OF THE PROJECT

265. Responsibility for the implementation and management of the Project will rest with the Ministry of Health (the Nutrition Division, the Health Education Unit and the Health Laboratory Services). Collaborating agencies will include the University of Ghana, which will have responsibility for undertaking surveys and preparing reports, and relevant NGOs. The Ghana Water and Sewerage Corporation (GWSC) will be in charge of water iodisation, while the Ministry of Trade and the Ghana Food Distribution Corporation will ensure the marketing of iodised salt.

LINKAGES/CONVERGENCE

266. Linkages will be established with the Water Supply Project in the area of water iodisation. Dissemination of information will be done effectively through linkages with the Social Mobilisation Programme.

GOVERNMENT CONTRIBUTIONS

267. Government contributions are expected to total approximately US$ 1,550,000 over the course of the Project.

PROJECT INPUTS

268. UNICEF will support the cost of the following project inputs, to the extent available financing permits:

Inputs	1991	1992	1993	1994	1995	Total
Control of IDD						
Epidemiological survey	1	0	0	0	0	1
Salt distribution survey	1	0	0	0	0	1
KAP study on IDD	1	0	0	0	0	1
Iodised capsules ('00s) equivalent oil	425	425	815	815	815	3295
Inserts for iodisation of water wells	0	25	30	30	25	110
Study on iodisation of salt	0	1	0	0	0	1
Iodine determination labs	0	1	1	0	0	2
Four-wheel drive vehicle	1	0	0	0	0	1

PROJECT BUDGET

(THOUSANDS OF US DOLLARS)

PROJECT/Activities	1991	1992	1993	1994	1995	TOTAL
4. Control of IDD						
Survey	10	10	0	0	10	30
Supply of iodised oil/capsules	10	10	20	20	20	80
Iodisation of water	0	15	20	10	10	55
Iodine testing labs	10	220	150	0	0	380
Training/exp. exchange visits	15	10	5	5	0	35
Communication and social mobilisation	20	25	15	10	10	80
Monitoring	20	0	0	20	0	40
PROJECT TOTAL	85	290	210	65	50	700
Funding.						
General Resources	85	85	60	55	50	335
Funded Sup Funding	0	0	0	0	0	0
Unfunded Sup Funding	0	205	150	10	0	365
PROJECT TOTAL	85	290	210	65	50	700

PROJECT: SUPPORT FOR THE SAFE MOTHERHOOD PROGRAMME

PROGRAMME SECTOR: HEALTH AND NUTRITION

IMPLEMENTING AND CO-OPERATING ORGANISATIONS:

PRINCIPAL COUNTERPART:	**MOH/MCH-FP DIVISION**
PRINCIPAL DONORS:	**UNICEF, UNFPA, USAID, WORLD BANK**
PROJECT BUDGET:	**US$ 848,000**

OVERVIEW

269. The Safe Motherhood Initiative (SMI) is a global effort to reduce mortality and morbidity among women caused by pregnancy-related conditions. This is expected to be achieved through improved coverage and quality of health services for women of child-bearing age, comprising pre-, peri- and post-natal care.

270. In Ghana, the health of women has been adversely affected by problems associated with pregnancy and child-bearing, as indicated by a Maternal Mortality Rate (MMR) of between five and ten per thousand live births, which is high in comparison with other developing countries with similar socio-economic characteristics. Contributory factors include: the absence of equipment, trained personnel and a functioning referral system at the district and sub-district levels of the health system; low coverage of services, as shown by the high number of births in rural areas (almost 40 percent) not supervised by either a doctor/trained nurse-midwife or TBA; ignorance among women about family planning practices, pregnancy-related problems and available health services; and socio-cultural influences such as pronatalism which contribute to a high fertility rate (Total Fertility Rate (TFR) of 6.4).

PROJECT COVERAGE/TARGETS

271. The Project will improve maternal and child care services available at strategic locations to approximately 74,000 of women of child bearing age (between 12 and 44 years), or approximately 60 percent of all those in this group, in Ashanti, Eastern and Western regions.

272. In the three selected regions, the Project will aim at reducing maternal mortality due to pregnancy-related conditions by 30 percent among a target group comprised of women above the age of 35 years, women with more than five deliveries and girls younger than 17 years.

PROJECT APPROACH

273. In response to this situation, the Ministry of Health (MOH) through the Division of Maternal and Child Health/Family Planning (MCH/FP) is launching a major Safe Motherhood Programme in all ten regions of the country. The MOH has divided the ten regions among various donors (e.g., UNICEF, UNFPA and USAID), but conceives programme as an integrated whole. UNICEF will support the Government's Safe Motherhood Programme in three regions (Ashanti, Eastern and Western Regions), focusing on the training of MCH staff and TBAs, equipping of health centres/posts and TBAs with MCH equipment and TBA kits, respectively, and provision of logistics support, particularly at the health centre/post level (Level B).

274. Of the 45 districts constituting the three regions, three districts (one in each region) will be supported by the District PHC Development Project, which will include all aspects of Safe Motherhood, beginning in 1991. Support for Safe Motherhood activities in the remaining 42 districts will be phased in during 1991-1994 at a rate of approximately ten districts each year.

ACTIVITIES

Collection of Baseline Data

275. Operational guidelines and policies have been formulated in relation to MCH/FP practices in Ghana. These include information collection and submission of reports on deliveries, pre- and post-natal consultations and family planning attendances, by Government, private and quasi-private institutions rendering these services. Seminars and workshops will be organised by regional MCH/FP staff in the three regions in collaboration with the national MCH/FP division, to upgrade the knowledge of medical officers, nurses, midwives and medical assistants to collect, compile and disseminate accurate information.

276. Baseline surveys will be conducted in each of the 45 districts in the three regions during the first quarter of 1991, to provide data on:

a. the incidence of peri-natal and neo-natal mortality and morbidity;

b. the inventory of equipment and supplies relating to MCH/FP at the district and sub-district levels;

c. the storage and distribution system for equipment and drugs relating to MCH/FP, at the district and sub-district levels;

d. the availability and skills of TBAs;

e. knowledge, attitudes and practices; and

f. the number of health facilities and personnel, both governmental and non-governmental.

277. The baseline surveys will be complemented by operations research studies to be commissioned in the second quarter of 1991, to provide:

a. a sample survey of those who conduct deliveries; and

b. a study of the risk factors in mortality and morbidity.

278. UNICEF will fund both the baseline surveys and the operations research studies.

Training/Refresher Courses for MCH Personnel and TBAs

279. As part of the regional TBA Training Programme, courses for master trainers will be held in the three regions for Principal Nursing Officers (PNOs)/Senior Nursing Officers (SNOs), six from each region, in the first quarter of 1991. Training will be organised by the national MCH/FP Division in collaboration with the national TBA training secretariat.

280. The national core trainers will then train 15 Master Trainers from each of the three regions who, in turn, will assist in the training of 504 midwives and the orientation of 250 medical assistants. These trainers will subsequently train 840 other Level B staff in their regions between 1991 and 1995.

281. Training courses, led by TBA trainers (from the TOT courses), will be held for 5,000 TBAs from each region, starting from the third quarter of 1991. Training content will be as indicated in the standardised Ministry of Health/UNICEF TBA training manual.

282. Refresher courses, led by Level B staff, will be held annually at the sub-district level for TBAs who have been trained.

283. Refresher courses will also be held annually (from 1992-1995) for 930 PNOs/PHNs/CHNs/Midwives (700 public and 230 private), 310 from each region. These will be conducted by the regional trainers and the District Health Management Teams. The focus will be on the upgrading and acquisition of skills to improve delivery of curative and preventive services, as well as on sensitising the local leadership regarding safe motherhood activities and survey results.

284. UNICEF will support the training courses by providing copies of the TBA training manual; TBA kits; stationery and supply items; honoraria for resource

persons; and payment for travel and subsistence and, in some cases, assistance with the payment of accommodation costs for staff and TBAs.

Upgrading Health Facilities

285. A viable system for pre-, peri- and post-natal care including a functioning referral system will be established to improve maternal services as well as the compilation of up-to-date data on risk factors and maternal mortality.

286. On the basis of the operations research studies on the inventory of equipment and supplies at the district and sub-district levels, the stocks of items such as instruments, expendables and other basic equipment will be replenished. The first replenishment will take place in the first quarter of 1992 and will subsequently take place annually until 1995.

287. As part of World Bank support, maternity hostels will be constructed at the district level to accommodate pregnant women whose condition requires regular treatment/check-ups unavailable in their villages rather than hospitalisation.

288. Facilities for blood transfusions, transport and two-way radio communication systems will receive urgent attention by other donors to improve referral systems and information flow between Levels A, B and C.

Supervision and Logistics

289. The staff of district hospitals and health centres/posts will be provided with motorcycles to facilitate their continual supervision of the activities of TBAs at the village level. In addition, quarterly meetings will be supported to bring together the TBAs and MCH staff at the health centre/post to discuss activities and approaches and identify gaps in terms of supplies and training.

Social Mobilisation

290. The main aim of this activity will be to empower the community in general, and mothers in particular, with information on the reduction of pregnancy-related health risks as well as the benefits of birth spacing. Emphasis will be put on the development of specific specialised communication materials to be used on radio and television. In addition, a song and drama adapted to various local languages will be produced at the national level.

291. At the various forums to be organised by the Regional SMCCSD for district authorities, revolutionary organs, and traditional and religious leaders, information on proper pre-natal care will be disseminated through the use of films, songs, flannel charts and other media. (See chapter on Social Mobilisation for more details on the SMCCSDs).

MONITORING

292. Monitoring indicators will be of two types :

a. Input indicators (the dates of delivery/distribution and quantities of equipment and supplies as well as vehicles; the number and scheduling of training courses; and the commissioning and completion of baseline surveys and operations research studies); and

b. Output indicators (the number of MOH staff and TBAs trained and the establishment of a comprehensive database on basic indicators (mortality/morbidity) as well as MCH/FP facilities and staff.

293. Monitoring information will be provided through the regular reporting system of the MOH, comprising:

a. Births and deaths registers;

b. Monthly reports submitted by Village Health Committees to Level B health facilities, on the number of deliveries conducted and quantities of drugs utilised by TBAs;

c. Monthly returns submitted by Level B health facilities to DHMTs on deliveries conducted, disease patterns and drug utilisation. Quarterly reports will also be submitted to DHMTs, District Administrations and Assemblies detailing the number of training courses/orientation/ seminars held and the enrolment of participants.

d. Quarterly reports submitted by DHMTs to the regional health administrations on the activities carried out within the district health system, the health status of the population and the utilisation of drugs and other supplies.

e. Quarterly reports prepared by the regional PNOs for submission to MOH headquarters in Accra.

294. Copies of the consolidated district- and regional-level reports will be provided to UNICEF. Information gathered regularly by the MOH will be supplemented by data from UNICEF's internal monitoring system (the Global Field Support System -- GFSS).

MANAGEMENT OF THE PROJECT

295. The Maternal Child Health/Family Planning (MCH/FP) Division will have overall responsibility for the execution of planned project activities and monitoring of inputs and outputs, as well as dialogue with UNICEF on the resolution of any problems which may emerge in the course of implementation. Relevant NGOs will also be involved.

296. At both regional and district levels, the MCH/FP Division will work in collaboration with the medical officer in charge of obstetrics and gynaecology at the regional and district hospital. It will be assisted in its task by the various levels of the national health system including:

a. The National TBA Training Secretariat which will organise the course for regional master trainers in 1991;

b. The regional health administrations, led by the Regional Directors of Medical Services, which will submit monitoring reports on a regular basis to the MOH in Accra (see preceding section);

c. With assistance from regional and national levels, the District Health Management Teams (DHMTs), led by the District Medical Officers (DMOs), will assist in the execution of baseline surveys and operations research studies (data collection and interpretation). They will also organise training of trainers (TOT) courses for Level B staff with assistance from the regional PHC staff. They will liaise with the District Administrations and non-health ministries/agencies/organisations (for social mobilisation activities) as well as submit monitoring reports to the regional health administrations on project implementation; and

d. Health staff at Level B will train TBAs, supervise Community Clinical Attendant (TBAs and Village Health Workers) and submit monitoring reports to the DHMTs.

COLLABORATION WITH OTHER PARTNERS

297. The national efforts in the area of Safe Motherhood will continue to be supported by a group of donors including UNFPA, UNICEF, USAID, the World Bank and NGOs such as the Christian Health Association of Ghana (CHAG), Save the Children Fund and the Ghana Private Midwives Association. The MCH/FP Division, under the Public Health Division of the MOH, will collaborate and will co-ordinate donor inputs, with assistance from the national team for traditional birth attendants training programme.

298. The activities of other donors participating in the SMI include:

a. construction of maternity hostels;

b. provision of anti-malaria tablets and ante-natal drugs at all midwifery centres;

c. provision of blood bank facilities and special gynecological instruments;

d. provision of two-way communication systems between first and second referral points;

e. provision of ambulances at health centres to convey emergency cases to the district hospitals; and

f. Re-training courses for public and private midwives.

LINKAGES AND CONVERGENCE

299. The Social Mobilisation Programme will develop the materials and media as well as organism community, governmental and non-governmental organisations to disseminate information contained in the UNESCO/UNICEF/WHO publication "Facts for Life". The Non-Formal Education Project, under the Basic Learning Needs Programme, will organism women's groups for the purpose of ensuring functional literacy including knowledge of essential health information.

CONSTRAINTS AND OPPORTUNITIES

300. Constraints include:

a. Inadequate staffing (including the posting of DMOs), weak management and insufficient planning in the health system, especially at the district level, may strain implementation capacity;

b. The irregularity and uneven quality of monitoring reports (the Project relies on the existing reporting system of the MOH which has suffered from irregular submission of reports and the non-availability of data); and

c. Potential difficulties in donor co-ordination, especially in the phasing of project activities, could lead to delays in the timely arrival of certain inputs.

GOVERNMENT CONTRIBUTIONS

301. The Government of Ghana will:

a. Ensure the provision of staff required for project implementation, particularly at the district and sub-district levels;

b. Provide and maintain office equipment and supplies required for project activities;

c. Bear the cost of fuel, night allowances and other staff allowances for training courses and, in some cases, provide accommodation for health personnel during training and workshops;

d. Identify and allocate budgetary resources for the recurrent costs of the Project including the operation and maintenance of physical facilities and project vehicles and equipment.

302. The total Government contribution to the Project will be equivalent to US$ 49 million.

303. Communities will make a contribution in cash and in kind towards the transportation and feeding of TBAs as well as the provision of containers for the storage of TBA delivery equipment.

PROJECT INPUTS

304. UNICEF will support the cost of the following project inputs, to the extent available financing permits:

Inputs	1991	1992	1993	1994	1995	Total
Support For Safe Motherhood Programme						0
Districts starting	9	11	11	11	0	42
Districts operating	9	20	31	42	42	144
Collection of baseline data	9	11	11	11	0	42
Operations research on pregnancy	3	0	0	3	0	6
Sets of training manuals	288	330	330	330	0	1278
Training sessions for:						
Master trainers (6/region - 10 days)	1	0	0	0	0	1
Trainers (2/level B), 10 days	3	3	3	3	0	12
level B staff (4/centre), 3 days	9	11	11	11	0	42
TBA training sessions (120/district):						
initial training for 28	90	110	110	110	0	420
retraining for 5 days	0	90	110	110	110	420
TBA kits	1080	1320	1320	1320	0	5040
MCH kits	45	55	55	55	0	210
Teaching equipment for training schools.	10					10
Motor bicycles	45	55	55	55	0	210
Half-yearly review sessions	90	200	310	420	420	1440

PROJECT BUDGET

(THOUSANDS OF US DOLLARS)

PROJECT/Activities	1991	1992	1993	1994	1995	TOTAL
5. Support for Safe Motherhood Prog.						
OR & baseline data	13	5	5	5	0	28
Training / refresher courses	59	86	86	86	37	354
Upgrading of health facilities	17	28	28	28	0	101
Supervision and logistics	10	55	75	83	89	312
Communication and social mobilisation	9	11	11	11	11	53
PROJECT TOTAL	108	185	205	213	137	848
Funding.						
General Resources	108	83	92	78	62	423
Funded Sup Funding	0	0	0	0	0	0
Unfunded Sup Funding	0	102	113	135	75	425
PROJECT TOTAL	108	185	205	213	137	848

BASIC LEARNING NEEDS[11]

SUMMARY

305. The programme on Basic Learning Needs consists of three projects: Life Skills in Primary School, Non-Formal Education and Early Childhood Development.

306. The Life Skills In Primary Schools Project aims at supporting the incorporation of the components of "Facts For Life" in the curricula of 10,120 primary and 5,000 junior secondary schools enrolling about 2.3 million children of 6-15 years of age all over the country. Besides supporting the design and production of resource books for about 100,000 teachers and supplementary reading materials for the pupils, the Project aims at linking the school system with communities in the promotion of convergent basic services, particularly in the ten districts selected from each of the ten Regions.

307. The Non-Formal Education Project will support the provision of basic knowledge and literacy skills to non-literate adults, especially women, and children not attending school. The project will be practical in orientation and, in addition to enhancing literacy skills, will seek to provide learners with essential basic knowledge and life skills they require to enhance their welfare and that of their children, particularly in the ten districts selected for District PHC Development.

308. The Early Childhood Development Project will seek to reduce women's workload and increase the schooling of young girls while promoting the physical, cognitive and psycho-motor development of children under six years of age. Whereas at the national level the Project will address such national issues as policy development and institutional strengthening, in the ten districts selected for District PHC Development it will, in addition, help to improve pre-school facilities and non-formal child care.

309. In order to address more directly the acute problem of illiteracy in the 9-14 age group, UNICEF Ghana will prepare a proposal for additional Supplementary Funds during 1991. A study of educational needs will be undertaken (in consultation with UNDP, UNESCO and the World Bank) to identify key points of intervention to help address the needs of this group and to ensure education for all.

[11] The term "Basic Learning Needs" has been used in this Programme of Co-operation, rather than the term "Basic Education" used by the World Conference on Education for All. This has been done purposely in order to avoid confusion with the Government of Ghana's use of "Basic Education" to refer only to the first nine years of primary and junior secondary schooling.

BACKGROUND

310. As stated in the Summary of the Situation Analysis, 67.5 percent of the population nine years of age and older, or approximately six million people, are illiterate. Moreover, there is a substantial gender gap with respect to illiteracy: some 58 percent of males in this age group are illiterate compared to 77 percent of females.

311. Only about two-thirds of primary school age (6-11) are enrolled in schools. Of those who do enrol, 27.1 percent of males and 35.1 percent of females drop out before completing their primary education. The higher drop out rate for girls reflects parental pressure on them to bring more social and economic returns to the family by looking after younger siblings, carrying out domestic chores, and participating in petty trading.

312. Among children between one and the school-going age of six, approximately ten percent (eight percent in 1987-1988) are enrolled in public and private pre-schools; the rest are left to the care of school-age sisters or left to themselves, since the mothers are always engaged in winning their family's daily bread.

313. The economic crisis of the last two decades explains these conditions. Government budget allocations for education fell by about 66 percent in real terms between 1979 and 1985, while the proportion of GDP devoted to education declined from six percent in 1976 to about one percent in 1983. Planning of education became a problem and was progressively reduced to crisis management. Inadequate basic instructional materials, particularly textbooks, equipment, stationery and other essential items seriously affected the quality of education at all levels. Food shortages especially in 1983 also led to shortening of school terms. The number of unqualified teachers in the pre-university education system had increased to almost half the total teaching force by 1985. The adult literacy programme that was introduced as far back in 1948 and reached its peak in 1960 dwindled in importance to a level that only NGOs and the Department of Community Development could maintain on their own.

314. To reverse this situation, an Education Reform Programme was launched in September 1987 with the aim of increasing school enrolment faster than the population growth rate, strengthening the relationship between educational content and the social and economic needs of the country, raising quality of education and ensuring financial sustainability. As a result, pre-university education has been reduced from 17 to 12 years catering for children of 6-15 years of age; a revised curriculum including Life Skills has been introduced in each of the nine classes of basic education; and user charges, such as textbook fees, have been introduced.

315. The Government has also recognised that non-formal education is essential for providing the population outside the formal education system with basic life skills, including vocational training. The Non-Formal Education Division of the

Ministry of Education (MOE) has, therefore, been assigned to educate the entire illiterate population with the goal of achieving 80-90 percent literacy by 1995 and eradicating illiteracy altogether by the end of the decade. To this end, pilot studies are currently under way in four selected districts, two each in the Upper East and Central Regions. Experience gained from these areas will enable the MOE to embark on a nation-wide programme.

PROBLEMS TO BE ADDRESSED BY THE PROGRAMME

316. The Programme addresses the following specific problems:

a. the lack of instruction manuals and supplementary reading materials on the newly introduced Life Skills syllabus in primary and junior secondary schools;

b. shortage of material resources to support the national functional literacy programme, and

c. the inadequacy of pre-school care particularly in rural communities.

PAST CO-OPERATION

317. During the 1986-1990 Programme of Co-operation, UNICEF's involvement in the education sector was limited to a number of relatively small interventions. Early in the programme cycle, UNICEF sponsored the establishment and start-up phase of the Integrated Community Centres for Employable Skills (ICCES), aimed at training school drop outs in vocations that can thrive on locally available materials and markets. The model proved successful and has since been expanded by the Ministry of Education to 91 centres, as compared to 40 in 1987 when UNICEF ended its involvement in the project. Between 1990 and 1994, an estimated 920 additional ICCES centres are expected to be established as a component of the Non-Formal Education Programme.

318. In the area of Early Childhood Development, assistance was given for the training of pre-school teachers, and for provision of play materials to community based day-care centres. Monitoring was difficult, as the responsibility for the establishment and supervision of pre-schools straddles several Government agencies. Whereas the Ghana National Commission on Children (GNCC) is responsible for overall advocacy, the Ministry of Education concerns itself with those children in the educational system (above six years of age) and limits responsibility to the training of pre-school teachers, when approached. On the other hand, the Department of Community Welfare (of the Ministry of Mobilisation and Social Welfare) concerns itself with the registration and supervision of day-care centres for children below four years of age. The initiative to establish and run pre-schools is, therefore, left to profit-oriented individuals, most of whom have established facilities in urban areas.

319. The Non-Formal Education and Early Childhood Development components of the proposed Programme build on past co-operation. The third component on Life Skills in Primary Schools is a new involvement. All these interventions will complement all other programme components, particularly in the ten selected districts.

PROPOSED PROGRAMME

320. The objective of the Proposed Programme is to equip children in the 3-15 year old age group and non-literate adults, particularly women, with basic knowledge and skills they require to enhance their welfare and that of their families.

Geographic Coverage and Target Population

321. To achieve its objective, the Programme aims at reaching:

a. 2.3 million children enrolled in all the 10,120 primary and 5,000 junior secondary schools in the country;

b. 50 percent of the estimated 220,000 children between one and six years of age in ten districts (one in each of the ten administrative regions of the country); and

c. 50 percent of the estimated 190,000 non-literate women in the above ten districts.

322. While activities in the ten targeted districts will all begin in 1991, special attention will be devoted to those districts in which the District PHC Development project will be phased in each year (e.g., two districts in 1991, another three in 1992 and the final five in 1993).

Programme Strategy

323. The Programme aims to achieve its objective by providing support to and accelerating:

a. the dissemination of life skills in all basic primary and junior secondary education;

b. implementation of functional literacy and continuing education for non-literate adults, particularly women; and

c. the promotion of low cost and community-based pre-schools in the communities where women will be engaged in functional literacy activities.

Complementarity and Linkages with Other Programmes

324. The Programme builds on, or reinforces all other programmes. As it focuses on the initiation and acceleration of basic educational development to communities as well as service providers, it serves, particularly in the ten districts selected for convergence of basic services, as a fore-runner as well as a framework for all UNICEF interventions as well as others aimed at improving the welfare of disadvantaged groups.

Constraints and Opportunities

325. Government policy in support of meeting the people's basic learning needs is in place, and relevant action has already been taken as part of the Educational Reform Programme of 1987. Nevertheless, the high rate of illiteracy among children in the 9-14 age group clearly indicates the need for a careful assessment of the efficacy of primary education and the additional measures needed to overcome this problem. It should be noted that the Rockefeller Foundation has funded an on-going study of the determinants of female drop-outs from primary school. In addition, in 1990 USAID provided US$ 35 million to support primary education for a period of five years.

326. Constraints may arise in two areas, particularly in the case of Non-Formal Education. First, staff on whose understanding and co-ordinated involvement the programme will depend, may find it more convenient to resort to the usual practice of sectoral and unilateral action. This will confuse beneficiaries and undermine the purpose of the programme, which is to respond to and build on communities' felt needs in a holistic manner. Second, a problem may arise from infrastructural weaknesses which may detract from the timely availability of supplies, thus frustrating the enthusiasm of communities, once such enthusiasm is generated. Particular attention will therefore have to be given to detailed planning and proper induction of key staff, particularly at local levels.

PROGRAMME BUDGET/TIMEFRAME

(THOUSANDS OF US DOLLARS)

PROJECT/Activities	1991	1992	1993	1994	1995	TOTAL
BASIC LEARNING NEEDS PROGRAMME						
1 Life Skills in Primary Schools	135	275	403	388	384	1585
2. Non Formal Education	111	253	171	267	249	1051
3. Early Childhood Development	42	39	57	83	72	293
SUBTOTAL	288	567	631	738	705	2929
Programme Support	99	84	100	86	90	459
TOTAL PROGRAMME	387	651	731	824	795	3388
Funding.						
General Resources	387	428	355	366	389	1925
Funded Sup Funding	0	0	0	0	0	0
Unfunded Sup Funding	0	223	376	458	406	1463
TOTAL PROGRAMME	387	651	731	824	795	3388

PROJECT: LIFE SKILLS IN PRIMARY SCHOOLS

PROGRAMME SECTOR: BASIC LEARNING NEEDS

IMPLEMENTING AND CO-OPERATING ORGANISATIONS:

PRINCIPAL COUNTERPART:	**MOE**
PRINCIPAL DONOR:	**UNICEF**
COLLABORATING AGENCIES:	**USAID, WORLD BANK**
PROJECT BUDGET:	**US$ 1,585,000**

OVERVIEW

327. One major outcome of the Educational Reform Programme of 1987 is the inclusion of a syllabus on Life Skills in the curricula of primary and junior secondary education, affecting children aged 6-15 years. Whereas the syllabus is being introduced satisfactorily in junior secondary schools, with the use of a single textbook by both pupils and teachers, this has not been possible in primary schools, for which neither reading materials for pupils nor source books for teachers could so far been made available.

328. During the 1991-1995 Programme of Co-operation, the Project aims at supporting the Division of Basic Education of the Ministry of Education to:

a. expand the syllabus for primary schools so as to ensure adequate treatment of all components of "Facts for Life";

b. produce reading materials for pupils and source books for teachers in all primary schools;

c. ensure the proper utilisation of the materials through adequate orientation of teachers; and

d. assess existing education curricula with a view to preparing a Supplementary Funded programme to address the literacy needs of children aged 9-14

GEOGRAPHIC COVERAGE/TARGETS

329. During the 1991-1995 programme period, 62,000 primary and 35,300 junior secondary school teachers will be provided with a resource book and given adequate orientation on its use. In addition, 1,700,000 primary and 625,000 junior secondary school pupils will also be provided with supplementary reading books.

PROJECT APPROACH

330. The Basic Education Division of MOE will review the content of the existing syllabus for adequacy with regard to Life Skills. Workshops including technicians and support staff will be conducted to review the syllabus and develop manuscripts on each of the components of the Life Skills syllabus. The manuscripts will be tested and reproduced for distribution to schools. This will be followed by the production of source books for teachers and reading materials for pupils. The orientation of teachers and distribution of resource books and reading materials will be closely monitored to converge with other UNICEF-assisted projects. In consultation with the MOE, UNESCO, the World Bank and USAID, in 1991 UNICEF staff will undertake a study of the methods and efficacy of primary school education, particularly with respect to literacy. The study is expected to identify key points of intervention and recommend specific projects and activities to be included in a Supplementary Funded Programme to be submitted to the UNICEF Executive Board in 1992.

ACTIVITIES

Material Development

331. During 1991, the Curriculum Research and Development Division (CRDD) of the Ministry of Education will review the contents of the current syllabus and develop ten manuscripts, one on each component of "Facts for Life", to serve as supplementary reading materials for pupils, and one manuscript containing all components to serve as a source book for teachers. This will involve four workshops of 18 days duration for ten technical experts each. UNICEF will cover stationery and subsistence costs.

Materials Production

332. A total of 2.3 million supplementary reading books and 100,000 resource books for teachers will be produced by the MOE/CRDD. The 100,000 resource books will be produced in 1991, while the supplementary readers will be produced in 1992. Manuscripts for supplementary readers on malaria, EPI, parasites and diarrhoea have already been developed, and other manuscripts on topics such as ARI, nutrition, Mother and Child Health and AIDs will be produced during 1991. UNICEF will support the cost of printing the resource books and supplementary readers.

Training of Trainers and Orientation of Teachers

333. This activity will consist of the following:

a. The Curriculum Research and Development Department (CRDD) of MOE will train 50 core trainers (five from each office of the ten Regional Directorates of Education) during November 1991;

b. Upon their return to their respective offices, these 50 core trainers will, in turn, conduct a five-day trainers' course for 330 district supervisors, three from each office of the 110 District Education Officers; and

c. Commencing in January 1992, the 330 district supervisors will organise five-day orientation seminars for approximately 100,000 primary and junior secondary school teachers on the contents of the syllabus, phased over three years during school vacations, with an average of 30,000-35,000 each year.

334. UNICEF will cover subsistence and transportation costs.

SUSTAINABILITY

335. It is expected that the manuals and supplementary readers last a minimum of five years, beyond which replacement is planned from collection of user fees and Government subsidies.

MONITORING

336. Activity outputs will be monitored through field visits, quarterly reports by MOE staff and yearly reviews, on the basis of which minor adjustments can be made. Major adjustments based on the recommendations of the Mid-Term Review in mid-1993. Key indicators to be used will be the number of students completing the Life Skills curriculum and the level of their knowledge on the subject, as evidenced by examination results and change in behaviour patterns.

337. In the ten districts selected for convergence of UNICEF assistance, the District Education Officers and their supervisory staff will encourage and ensure that the pupils and their teachers link with Government field staff and communities in applying their knowledge of life skills. The relevance of the syllabus will also be verified jointly by the District Education Officers and UNICEF staff as an input for possible review of the syllabus and related subjects in 1994.

MANAGEMENT OF THE PROJECT

338. The responsibility for the design and production of materials rests with the CRDD of the Division of Basic Education/MOE. The Inspectorate Division will ensure the supply and proper utilisation of the materials. The Regional Directors of Education will supervise and back-stop the District Education Officers, whose staff will supervise all schools in the district.

LINKAGES/CONVERGENCE

339. Equipping students with knowledge on Life Skills has direct linkages with all UNICEF interventions. Children relate their knowledge to their families, whose behaviour and practices all social sector interventions aim to influence.

340. In their respective communities, particularly in the ten districts where UNICEF assistance will converge, the project will provide stimulus to teachers and students to provide active support to overall community development undertakings.

CO-ORDINATION WITH OTHER PARTNERS

341. The Division of Basic Education of MOE is the focal point in its area of jurisdiction and, thus, co-ordinates external assistance as well as the involvement of national agencies. UNICEF also relates regularly with USAID and the World Bank, who major external supporters of Basic Education.

GOVERNMENT CONTRIBUTION

342. During 1991-1995, the Government will allocate an equivalent of US$ 127,000 to the development and production of materials, as noted above, in addition to regular expenditures for Basic Education.

PROJECT INPUTS

343. UNICEF will support the cost of the following project inputs, to the extent available financing permits:

Inputs	1991	1992	1993	1994	1995	Total
Life Skills in Primary Schools						
Manuscript development workshops (18 days	4	0	0	0	0	4
Teachers' resource books (in '000)	100					
Supplementary reading books ('000)	0	345	690	690	598	2323
Five-day sessions for training of:						
- 50 core trainers	2					
- 330 district trainers	110	0	0	0	0	110
- 100,000 teachers	0	440	880	880	770	2970

PROJECT BUDGET

(THOUSANDS OF US DOLLARS)

PROJECT/Activities	1991	1992	1993	1994	1995	TOTAL
BASIC LEARNING NEEDS PROGRAMME						
1 Life Skills in Primary Schools						
Material development	**23**	23	15	0	20	81
Material production	**75**	158	200	200	200	833
Training / orientation	**37**	94	188	188	164	671
PROJECT TOTAL	**135**	275	403	388	384	1585
Funding.						
General Resources	**135**	121	121	116	115	608
Funded Sup Funding	**0**	0	0	0	0	0
Unfunded Sup Funding	**0**	154	282	272	269	977
PROJECT TOTAL	**135**	275	403	388	384	1585

PROJECT: NON-FORMAL EDUCATION

PROGRAMME SECTOR: BASIC LEARNING NEEDS

IMPLEMENTING AND CO-OPERATING ORGANISATIONS:

PRINCIPAL COUNTERPART:	**MOE/NON-FORMAL EDUCATION DIVISION**
PRINCIPAL DONOR:	**UNICEF**
COLLABORATING AGENCIES:	**MLG/DCD, ODA**
PROJECT BUDGET:	**US$ 1,051,000**

OVERVIEW

344. The literacy rate of the population nine years and over is 50.2 percent. Whereas the literacy of males is 42 percent, that of females is only 23 percent. Rates of morbidity, mortality, malnutrition and fertility are higher among the females who are illiterate than among those who are literate. This same reality is reflected in the status of their children. Besides the decisively negative influence illiteracy has on the women's reproductivity and productivity, it also determines their aspirations, prospects of social mobility, perceptions of values in relation to the family and household as well as their ability to enhance the survival and development of their children.

345. The project therefore aims to equip 50 percent of rural women in the ten selected districts who have limited or no formal education with basic knowledge of and skills in literacy, health, nutrition, environment, labour reduction methods and devices, income generation, fertility management, etc., in order to enable them to improve their economic and social welfare and that of their families, particularly their children.

346. Responsibility for the implementation of the project will rest with the Non-Formal Education Division of the MOE. The Division develops programmes and co-ordinates inter-sectoral activities with a view to revitalising the infrastructure for functional literacy throughout the country in order to eradicate illiteracy by the year 2000. It also provides materials, teaching aids, facilitator training and distance learning, as well as community-based self-employment opportunities to link literacy with functional skills (i.e., vocational and managerial skills), thus ensuring that adults and school leavers who are literate do not relapse into illiteracy.

PROJECT COVERAGE/TARGETS

347. Approximately 156,100 women, or 50 percent of the illiterate female population of the ten districts selected for convergence of basic services, will directly benefit

from the project. Within the ten districts, priority attention each year will be given to those districts in which the District PHC Development project is being phased in (two districts in 1991, another three in 1992 and the final five in 1993).

PROJECT APPROACH

348. The project is aimed at improving literacy by concientising rural women, particularly the non-literate, about the factors which define their quality of life as well as by providing them with knowledge and methods which they can adopt to enhance their own welfare. Thus, the project builds on dialogue with and among women to identify and prioritise their needs and to help them organise themselves to seek and adopt methods for meeting those needs.

349. To facilitate such a dialogue, and to channel and monitor required support, Unit Committees in each of the ten districts, representing communities of up to 1,000 inhabitants, will be encouraged to form women's groups of at least 30 members. The formation of the groups (about 270 in each district) will take place in stages: (approximately 54 each year). Ten to 15 such groupings will be assisted by one facilitator for about two years. The facilitator will operate in close liaison with the Unit Committee which will oversee the women's groups and also link them with Government field staff (health, nutrition, water, and agricultural extension, etc.).

350. The first step will involve the selection of communities and the initiation of discussions with their elders and/or Unit Committee to create awareness and generate interest in functional literacy for self-improvement. This will be followed by the identification and training of two focal persons, ideally from among members of the Unit Committee, to assist facilitators to establish and begin discussion-based literacy classes, using basic functional literacy primers built around topics related to the daily learning needs of women. In the process, relevant skills for self employment and labour reduction methods, among other things, will be identified and supported through the branches of development agencies operating in the target communities.

ACTIVITIES

Materials Development

351. During 1991 and 1992, the Non-Formal Education Division will develop manuscripts for 15 primers (starters) and 15 post-literacy supplements on each of the ten components of "Facts for Life" and five other subjects directly related to women. This will involve provision of subsistence allowance, graphic art materials, office equipment, stationery and other logistics support required for eight workshops, each of three weeks duration and each including seven technical experts.

352. Handbooks for facilitators and manuals for trainers will accompany the learning materials. Teaching aids such as "Snakes and Ladders" games, playing cards, jigsaw puzzles, word games, puppets, and so forth, will be developed with the participation of the learners to activate the learning process.

Materials Production

353. During 1992 and 1993, the following materials will be produced and distributed by the Non-Formal Education Division of the Ministry:

a. 24,000 sets of 15 primers and an equal number of literacy supplements for 1,168 communities in the ten districts (15 sets for each community);

b. approximately 4,000 handbooks for community focal points, Unit Committee facilitators and supervisors in ten selected districts;

354. Drama will be used to draw attention to opportunities for self-improvement and will give rise to dialogues on how individuals and the community can initiate and sustain the process of self-improvement (in vocations, health, maternal and child care, etc.). Towards this end, 15 scripts (five each year during 1991-1993) will be produced in seven local languages through the involvement of professional script writers and theatre groups. The 15 scripts will be played by professionals and filmed/recorded for use in other communities and for radio and television programmes. Ten district theatre groups will be supported to role-play an average of 10-12 times in convenient locations every year.

355. Support will include cash assistance, transport and office equipment and supply of radio receivers. The production of scripts will be supported with video cameras and editing equipment, audio recording sets and accessories, means of transport and with financial assistance for workshop costs.

Training

356. The following key staff and community focal points will be trained on the substance of the materials and on teaching techniques:

a. 40 regional trainers (four per region for ten days in 1991 and five days yearly thereafter);

b. 50 district trainers (five for each of the ten districts for ten days in 1991 and 5 days a year thereafter);

c. 90 facilitators (nine for each of the ten districts for 15 days in 1992 and for ten days annually thereafter); and

d. 2,540 community focal persons (two from each of the approximately 1,200 communities in a district).

Logistics Support

357. Support will be provided to the District Education Officer in each of the ten selected districts in the form of public address systems, audio-visual equipment, office supplies and equipment, etc. The District Education Officer will link with the Social Mobilisation Committees for Child Survival and Development (SMCCSDs) at the district, sub-district and Unit Committee levels to complement their training and orientation and to provide necessary logistical support. Each Education Officer will also be responsible for ensuring that the Non-Formal Education facilitators that he or she supervises co-ordinate their activities with the SMCCSDs and with the Unit Committee members.

MONITORING

358. Activity outputs, such as the number of women trained and increases in enrolment and retention of learners in literacy classes, will be monitored by MOE staff at every stage and reported on every six months. Joint field trips, semi-annual reports and annual reviews will provide the basis for minor adjustments. The Mid-Term Review to be undertaken in 1993 will provide the basis for any major adjustments which may be required.

MANAGEMENT OF THE PROJECT

359. The Non-Formal Education Division of the MOE will be responsible for the implementation of the Project through the following organs:

a. A National Advisory Committee, which will assist with the co-ordination of inter-sectoral activities relating to policy and participation modalities;

b. The Materials Development Department of the MOE at the national level, which will co-ordinate and undertake the development of materials required for the project;

c. The Field Operations Department of the MOE at the national level, which will provide training supplies and will monitor and evaluate field activities;

d. At the local levels, Regional and District Directors, who will handle local planning, training of facilitators and community focal persons as well as supervision and monitoring of implementation. Regional and District Advisory Committees will assist in the co-ordination of the inter-sectoral activities with the involvement of relevant NGOs;

e. District facilitators (about 30 in each of the ten selected districts), who will supervise the operations of community focal persons identified and trained from among each community.

LINKAGES/CONVERGENCE

360. The Project is very closely linked with all programmes and their components, especially the Social Mobilisation Programme. As the Project provides basic development education not only to communities but also to service providers, it serves, particularly in the ten districts selected for convergence, as a fore-runner and framework for all UNICEF interventions and others aimed at socio-economic development.

361. Various national and external organisations will support the project. Among the major national partners are the National Commission for Women and Development, the 31st December Women's Movement, the Departments of Social Welfare and Community Development, and youth organisations. External collaborators include CIDA, FAO, ODA, UNDP, UNFPA, UNIFEM, WHO and the World Bank.

362. Co-ordination among all collaborators and projects will be provided by the Advisory Committee at all levels as well as by the Social Sector Sub-Committees of the District Assemblies in each of the ten districts.

GOVERNMENT CONTRIBUTION

363. Ten percent of the total budget of the Ministry of Education is allocated for Non-Formal Education. Government contributions for the development of physical facilities and preparation of basic training materials during 1990 will be equivalent to US$ 1.8 million. An amount equivalent to US$ 755,000 has also been mobilised from other local and external sources to meet medium-term investment costs. The Government allocation for programming and support services during 1991 is expected to increase to an equivalent of US$ 4.6 million in 1991, when the Programme will be expanded from the 26 districts in 1990 to all the 110 districts.

PROJECT INPUTS

364. UNICEF will support the cost of the following project inputs, to the extent available financing permits:

Inputs	1991	1992	1993	1994	1995	Total
Non-Formal Education					0	
					0	
starting Town/Area Councils	10	20	30	40	0	100
operating Town/Area Councils	10	30	60	100	100	100
Graphic art materials & stationery pks	4	4	0		0	8
Video camera and editing bench	1	0	1		0	2
3-week workshops of 7 technicians	4	4			8	16
Sets of 15 primers	2400	4800	7200	9600	0	24000
Sets of 15 post literacy readers	0	2400	4800	7200	9600	24000
Handbooks for 100 T/A Council focal persons and 10 supervisors	110	0	110	0	110	330
Handbooks for 1200 UC focal persons	1200	0	1200	0	1200	3600
Training sessions for:						
- 40 regional trainers (10 days in 1991 and 5 days from 1992)	2	2	2	2	2 0	10
- 50 district trainers (10 days in 1991 and 5 days from 1992)	2	2	2	2	2 0	10
- 90 district facilitators (15 days in 1991 and 10 days from 1992)	10	10	10	10	10	50
- 2540 UC focal persons (5 days initial and 3 days as of '92)	10	100	100	100	100	410
Audio tape recorders and tapes	10	20	30	40	0	100
Sets of type writer & duplicator	10	0	0	10	0	20
Motor cycles	10	0	0	10	0	20
Public address system	10	20	30	40	0	100
Film projectors - 16MM	0	10	0	10	0	20
Bicycles	10	20	30	40	0	100
Vehicle - four-wheel drive	0	1	0	0	0	1
Lighting equipment	10	0	0	0	0	10

PROJECT BUDGET

(THOUSANDS OF US DOLLARS)

PROJECT/Activities	1991	1992	1993	1994	1995	TOTAL
2. Non Formal Education						
Material development	41	20	0	20	0	81
Material production	20	171	125	170	114	600
Training	23	28	28	28	135	242
Logistics	27	34	18	49	0	128
PROJECT TOTAL	111	253	171	267	249	1051
Funding.						
General Resources	111	184	77	80	112	564
Funded Sup Funding	0	0	0	0	0	0
Unfunded Sup Funding	0	69	94	187	137	487
PROJECT TOTAL	111	253	171	267	249	1051

PROJECT: EARLY CHILDHOOD DEVELOPMENT

PROGRAMME SECTOR: BASIC LEARNING NEEDS

IMPLEMENTING AND CO-OPERATING ORGANISATIONS:

PRINCIPAL COUNTERPART:	**MOE**
PRINCIPAL DONORS:	**UNICEF**
COLLABORATING AGENCIES:	**GNCC**
PROJECT BUDGET:	**US$ 293,000**

OVERVIEW

365. Approximately ten percent of the nation's 2.9 children under the school-going age of six have access to some form of pre-school care through 6,000 pre-schools and day-care centres. Most of these children live in urban areas and have parents who can afford the fees. The remaining 90 percent of Ghanaian children, mostly in rural communities, are left to themselves or in the care of their school-age sisters, who are often retained from school for this purpose. Others are carried on their mothers' backs. A majority of mothers rarely have time off from their daily work to care for their pre-school children.

366. Besides being denied the opportunity to develop adequately and prepare for school enrolment and attendance, these children are exposed to environmental and other hazards due to inadequate physical supervision, all of which contribute to the high U5MR of 155 per thousand.

367. These problems are caused, on the one hand, by insufficient community awareness of the importance of facilities for pre-school age children and, on the other hand, by the lack of a national policy defining central responsibility for the establishment and expansion of community-based and low cost child care facilities.

368. Presently, programme implementation is being adversely affected by a lack of co-ordination among the several Government agencies involved in pre-school education and services. These agencies include: the Ghana National Commission on Children (GNCC), which advocates for the establishment and proper management of pre-schools; the Ministry of Education/Ghana Education Service (GES), which also encourages an 18-24 month exposure to pre-schools before enrolment in basic education, but only limits itself to the training of pre-school teachers at their model centres; and the Ministry of Mobilisation and Social Welfare/Department of Social Welfare (DCW), which concerns itself with the registration and supervision of day-care centres for children under four years of age. The establishment of the centres per se is left to individual and often profit-oriented initiators.

369. In addition to addressing national policy development issues and institutional strengthening for national level co-ordination, the Early Childhood Development Project is aimed at assisting communities to establish child care facilities they can afford and manage. The latter objective will be pursued in conjunction with functional literacy projects in the ten districts selected for non-formal education and convergence of other basic services.

370. Responsibility for the implementation of community-based ECD will rest with the Social Sector Sub-Committees of the District Assemblies in each of the ten districts. The 31st December Women's Movement, the Department of Social Welfare, the Department of Community Development, the Non-Formal Education Division and the Ghana Education Service will also play important roles.

PROJECT COVERAGE/TARGETS

371. The Project will provide services to approximately 50,000 children between two and six years of age (40 percent of those in the relevant age group) in the ten districts, to be organised in community-based and managed pre-school facilities. This will involve the establishment of 96 centres in 19 Town Council and 77 Area Councils and in 650 of the 1,268 Unit Committees in the ten districts.

PROJECT APPROACH

372. At the national level, special studies and policy workshops will be supported through the Ghana National Commission on Children, media such as specialised children's newsletters to augment advocacy, and through support for the development and implementation of a national policy on pre-school education and day-care.

373. Close links will be maintained with all other UNICEF-assisted projects in each of the ten selected districts, especially with functional literacy activities, through which Unit Committees and women's learning groups can be motivated and assisted to bring their children together. As a result of these efforts, it is expected that existing facilities in communities will be increasingly utilised and gradually upgraded. The initial focus will be on the creation of awareness, followed by the mobilisation of support and improvement of facilities and services.

ACTIVITIES

Institutional Strengthening

374. The GNCC will promote the establishment of a National Advisory Council (with representation drawn from the above-mentioned Government agencies and NGOs engaged in pre-school education) to spearhead the formulation and adoption of a national pre-school and day-care policy. A major seminar will be organised in 1991

to facilitate the development and activation of policy reformulation and guidelines on pre-schools. Technical papers that can facilitate the process will be produced for the workshop. Similar workshops will be organised in subsequent years for the purpose of reviewing progress on policy implementation. To further complement this effort and, in addition, to raise public awareness of the GNCC, the latter organisation will initiate and co-ordinate the publication of 24,000 copies of a quarterly newsletter on Early Childhood Development for distribution to 6,000 ECD centres. UNICEF will provide technical assistance and material support required for the seminar, production of technical papers as well as for the publication of the newsletter.

Development of Curriculum and Training Materials

375. With a view to establishing uniform standards of training for pre-school trainers and attendants, a single curriculum will be developed in 1991 by the Ghana Education Service, in consultation with the Department of Social Welfare. Based on the curriculum, materials for training trainers, pre-school teachers and community day-care attendants will be developed. The Ghana National Commission on Children will provide overall co-ordination. UNICEF will provide technical assistance and will support the cost of the curriculum development workshop and the production of the curriculum and training materials.

Training of Pre-School Teachers

376. Following the development of a revised curriculum in 1991, the Ghana Education Service will, in collaboration with the GNCC, organise one-week training seminars in phases at the national level. A total of 20 regional and 20 district trainers will participate in the workshop and will, in turn, each train approximately 60 pre-school teachers in their respective districts during 1991 and 1992. The pre-school teachers will, after their training, each be responsible for training community day-care attendants in their districts. UNICEF will support the costs of the training of trainers at the national level and training activities in the ten districts.

Establishment of Community Child Care Centres

377. Unit Committees in the ten districts selected for convergence of basic services will be assisted to establish child care centres and, in collaboration with women's groups, to equip and manage pre-school and child care centres. Whereas overall co-ordination will rest with the Social Sector Sub-Committees of District Assemblies, the Assemblyman or Assemblywoman elected by each Unit Committee will oversee the management of the centres through the communities' Unit Committees. (See paragraph 111 for details on the Unit Committee structure).

378. UNICEF assistance will be in the form technical assistance and provision of essential but locally unavailable teaching aids and support for the cost of training centre attendants.

MONITORING

379. All activity outputs will be monitored at every stage every six months. Key indicators will include the number of functioning centres, the number of children in each centre and the services provided. Joint field trips with officials from relevant agencies, quarterly reports by GNCC and the Department of Social Welfare, and annual reviews will be used to highlight developments and address operational issues. The Mid-Term Review in mid-1993 will provide the basis for any required adjustments.

MANAGEMENT OF THE PROJECT

380. The Social Sector Committees of District Assemblies will manage and monitor implementation through the sector ministries, agencies and NGOs represented in the districts. The Non-Formal Education Division of the MOE and the 31st December Women's Movement, in particular, will play catalytic roles. At the community level, the communities' Unit Committees and women's groups will be responsible for implementation. In addition, the relevant Assemblymen and Assemblywomen will also facilitate implementation.

LINKAGES/CONVERGENCE

381. The aim is to promote the establishment of community-based facilities for children as a focus of attention for the community. All interventions, at least those supported by UNICEF, will therefore be expected to be channelled to converge around these facilities. The Social Sector Sub-Committees of the District Assemblies in the ten selected districts will ensure the necessary level of co-ordination at that level to achieve the objectives of the project.

GOVERNMENT CONTRIBUTION

382. Besides the considerable staff time to be channeled for the different aspects of the Project, it is expected that the contribution of communities (labour, feeding, etc.) in the establishment and management of child-care centres will be equivalent to approximately US$ 1.9 million.

PROJECT INPUTS

383. UNICEF will support the cost of the following project inputs, to the extent available financing permits:

Inputs	1991	1992	1993	1994	1995	Total
BASIC LEARNING NEEDS PROGRAMME						
Early Childhood Development						
Starting Town/Area Councils	10	20	30	40	0	100
Operating Town/Area Councils	10	30	60	100	100	100
Technical papers for policy seminar	10	0	0	0	0	10
Policy and follow-up seminars of 30 (7 da	1	1	1	1	1	5
Quarterly newsletter ('000 copies)	12	24	24	24	24	108
Training material workshop (10 persons)	1	0	0	0	0	1
Sets of training material for:						
- regional trainers	40	0	0	40	0	80
- district trainers	30	0	0	30	0	60
- district pre-school teachers	200	0	200	0	200	600
- community day care attendants	240	480	720	960	0	2400
Training sessions for:						
- 20 reg & 10 HQ trainers (2 weeks)	1	0	0	1	0	2
- 20 district (PHC) trainers (7 days)	1	0	0	1	0	2
- 200 pre-school teachers (7 days)	10	0	10	0	10	30
- 2,400 com. day-care attendants	10	30	60	100	100	300
Sets of teaching aids for :						
- district level trainers	1	0	0	1	0	2
- Unit Committee day-care centres	240	720	1200	1680	1200	5040

PROJECT BUDGET

(THOUSANDS OF US DOLLARS)

PROJECT/Activities	1991	1992	1993	1994	1995	TOTAL
3. Early Childhood Development						
Inst. strengthening	18	20	20	20	20	98
Development of cur & t. Materia	5	2	3	4	2	16
Training	14	8	17	30	28	97
Teaching aids	5	9	17	29	22	82
PROJECT TOTAL	42	39	57	83	72	293
Funding.						
General Resources	42	39	57	83	72	293
Funded Sup Funding	0	0	0	0	0	0
Unfunded Sup Funding	0	0	0	0	0	0
PROJECT TOTAL	42	39	57	83	72	293

WATER AND SANITATION PROGRAMME

SUMMARY

384. The Water and Sanitation Programme aims at using a community participatory process and cost effective and appropriate technology, to increase access to safe water and sanitation for a significant proportion of the rural population who are without such facilities, thus alleviating their suffering from water- and excreta-related diseases and lessening the burden of carrying water over long distances. The Programme consists of two projects: Rural Water Supply (Guinea Worm Eradication) and Environmental and Domestic Sanitation.

385. The Rural Water Supply Project focuses primarily on small communities of less than 500 inhabitants and, to a lesser extent, on the disadvantaged sections of larger communities of between 500 and 5,000 inhabitants. It will benefit approximately 620,000 people. Co-ordinated efforts will be made within the Project to assist the MOH/Global 2000 Guinea Worm Eradication Programme, through the provision of safe water supplies to Guinea worm endemic areas, social mobilisation, education, promoting the use of filters and chemical agents to treat local water supplies and the establishment of an effective surveillance system.

386. The Environmental and Domestic Sanitation Project will run concurrently with and complement the Rural Water Supply Project. It aims at increasing rural sanitation coverage, with a primary focus on communities of less than 500 inhabitants. The project will focus exclusively on the promotion and construction of household Ventilated Improved Pit (VIP) latrines, proper refuse disposal methods, and intensification of health and hygiene education. Emphasis will be placed on sustainability and the improvement of knowledge and practices related to personal hygiene and affordable sanitation, especially in vulnerable communities. Moreover, in conjunction with the Mobilisation Programme and supported by the efforts of the Department of Community Development (DCD), it will seek to improve knowledge and practices related to personal hygiene and sanitation. The project, to be implemented jointly by the Ghana Water and Sewerage Corporation (GWSC), the Department of Community Development (DCD) and the Ministry of Health (MOH), will construct 1,200 household demonstration units to directly serve approximately 60,000 rural people.

BACKGROUND

387. Water-related diseases remain a major cause of morbidity and mortality among children in Ghana. Acute diarrhoea, claims 5,300 lives every year and Dracunculiasis (Guinea worm) and schistosomiasis continue to have a significant negative impact on many others, reducing the time children spend in school and the number of productive days that adults and children spend in essential agricultural activities. For example, it is estimated that an average farmer loses 50

productive days annually due to incapacitation caused by Guinea worm infection, precisely at the time when farming activities reach their peak. In addition to the direct impact of water-related diseases on their victims, this loss of productive capacity is a major factor contributing to the problem of malnutrition and over-burdening of women.

388. A review of water supply and sanitation services in Ghana at the end of the International Drinking Water Supply and Sanitation Decade (1981-1990), shows an extremely unsatisfactory situation. Access to clean water supplies remains low (approximately 49 percent nationally), and access to adequate sanitary facilities is even lower (27 percent nationally). Access to these services is heavily concentrated in urban areas, as a large proportion of resources spent in the water and sanitation sector has supported the provision of large, mechanised water systems to communities of more than 5,000 inhabitants. Because of this concentration, approximately 90 percent of the urban population (which totals only 30 percent of Ghana's population) has access to safe water and 50 percent to sanitation. In contrast, only 21 percent of the rural population has access to safe water and only 15 percent to sanitation.

389. Among the rural population, those living in communities of fewer than 500 inhabitants, some 6.7 million people, representing 46 percent of the country's total population, are particularly deprived. Water supply coverage for this population group is only about 15 percent and sanitation coverage is negligible.

390. Due to this extremely low service coverage, acute diarrhoea, schistosomiasis, Guinea worm, typhoid and other water related diseases are prevalent in these communities. While detailed epidemiological data is not available for all water-related diseases, a national case search for Guinea worm was conducted in 1989 by the Ministry of Health and Global 2000. This study of 95 percent of all rural villages, found that approximately 6,900 villages are Guinea worm endemic, with a total of about 180,000 individual cases.

391. Women and children are particularly affected by the lack of service coverage, yet they have the main responsibility for collecting water in all villages in Ghana. This usually means walking a distance of five to six kilometres carrying heavy loads of water (usually contaminated) several times a day. In many cases, the distance travelled to collect water may exceed ten kilometres.

392. Efforts to increase service coverage and improve the situation of women and children are hampered by institutional difficulties. Thus, expenditure on, and responsibility for, environmental services is fragmented among several agencies such as the Ministries of Health, Works and Housing, Local Government, the Environmental Protection Council and the Ghana Water and Sewerage Corporation. This leads to a lack of co-ordination and effectiveness in the formulation of strategies and the delivery of services.

Government Policy and Structure

393. Within the Government, the Ghana Water and Sewerage Corporation (GWSC), established in 1966 by an Act of Parliament, is solely responsible for the provision, distribution and conservation of drinking water for public, domestic and industrial purposes. It now operates over 200 pipe-borne water supply systems of various capacities throughout the country. To respond to the urgent needs of the rural population, a Rural Water Division was created within the GWSC in 1987. Under GWSC's Five Year Rehabilitation and Development Plan (1987-1992), the Rural Water Division proposes to a) sink 10,000 hand dug wells in over 7,500 communities with populations below 500, thus benefiting more than 2.4 million people and over; and b) drill 6,000 wells fitted with handpumps for over 1,000 villages with populations between 500 to 2,000, benefiting 1.1 million people. These activities are expected to increase rural water coverage to 60 percent.

394. The Department of Community Development (DCD) is the government agency within the Ministry of Local Government 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. It therefore complements the staff and activities of GWSC. As the GWSC has no staff below the regional level, it is DCD staff who have primary responsibility for the implementation of water and sanitation programmes at the district and community levels.

395. The Ministry of Health has primary responsibility for environmental health and sanitation and assists in the promotion of health education related to environmental sanitation, through the Division of Environmental Health. This Division focuses largely on the promotion and implementation of hygienic sanitary practices and supervises the Health Inspectorate. In addition, the Ministry of Health serves as the focal point for Government involvement in the Guinea Worm Eradication Programme, being undertaken jointly with Global 2000 and the Bank for Credit and Commerce International.

396. The District Assemblies are expected to play key roles in the planning, implementation and monitoring of all development efforts at the district level as well as in resource mobilisation and overall leadership.

397. Implementation constraints affecting water supply and sanitation programmes reflect a number of problems related to the interaction between the various agencies involved in the sector. Existing institutional capacity is inadequate and cannot support the rapid development and maintenance of rural water supply and sanitation facilities. Despite the active involvement of Government, multilateral, bilateral non-governmental organisations in the activities of the International Drinking Water and Sanitation Decade, the impact on the population's health status has been less than hoped for, primarily due to a lack of adequate emphasis on

improving knowledge concerning environmental sanitation as well as ensuring adequate maintenance.

398. In addition, the absence of a co-ordinating machinery has contributed to a lack of clarity regarding the roles of the various national agencies involved in the sector. It has also hindered complementarity and integration of efforts by national agencies, donors and NGOs.

399. Finally, the sector has suffered from a lack of both human and financial resources at all levels, thus impeding effective implementation. Although UNICEF, the World Bank, United Nations Development Programme (UNDP), Canadian International Development Agency (CIDA), KFW, Japanese International Co-operation Agency (JICA), World Vision International, Water Aid and other donors have provided substantial resources for the construction of water supply systems in selected areas, the impact on overall coverage has been limited. Within GWSC, there is a lack of adequately trained personnel at the district and community levels to implement, supervise and monitor the installation and maintenance of water supply and sanitation systems.

PAST CO-OPERATION

400. The water supply component of the 1986-90 Programme of Co-operation has been relatively successful, particularly in the delivery of drilling equipment for use by GWSC and in improving water supply in small rural communities. Nonetheless, the programme has been seriously constrained by limited technical manpower at the community level, inadequate community mobilisation and involvement, and lack of inter-ministerial co-operation between GWSC and the Department of Community Development (DCD).

401. In the area of sanitation, UNICEF contribution has been limited to the promotion and establishment of the Kumasi Ventilated Improved Pit (KVIP) latrines. Experience shows that this technology has not been widely adopted in small rural villages, primarily because of its relative sophistication and high cost. In contrast, limited emphasis has been placed on promoting household latrines, refuse disposal, food hygiene and drainage, all of which may offer more culturally acceptable solutions to the problems of small communities.

PROPOSED PROGRAMME

402. The UNICEF Water and Sanitation Programme aims at improving the health and productivity of village communities through the provision of improved water supply and sanitation, with an emphasis on villages with fewer than 500 inhabitants, which have not so far benefited significantly from the development of water resources in Ghana. The programme is also expected to directly contribute to the national goal of eradicating Guinea worm by 1993. The Water and Sanitation

Programme will provide strong support to the Primary Health Care (PHC) Programme of the Government and, at the same time, will address those constraints that have hindered effective implementation of water and sanitation programmes in the past.

403. Based on the lessons learned during the past programme cycle, full consideration will be given to the following factors in implementing the 1991-1995 Programme of Co-operation:

a. The need for active community participation at all levels, in planning, decision-making and programme implementation;

b. Reliance on simple, affordable and sustainable technologies;

c. Active involvement of women in all aspects of the programme and strengthening of community artisan base through training and exchange visits;

d. Intensification of educational activities on health, hygiene and water use;

e. Strengthening of linkages between GWSC, DCD and MOH in order to ensure effective and integrated implementation; and

f. Establishing an effective surveillance and reporting system for water- and excreta-related diseases.

Geographic Coverage and Target Population

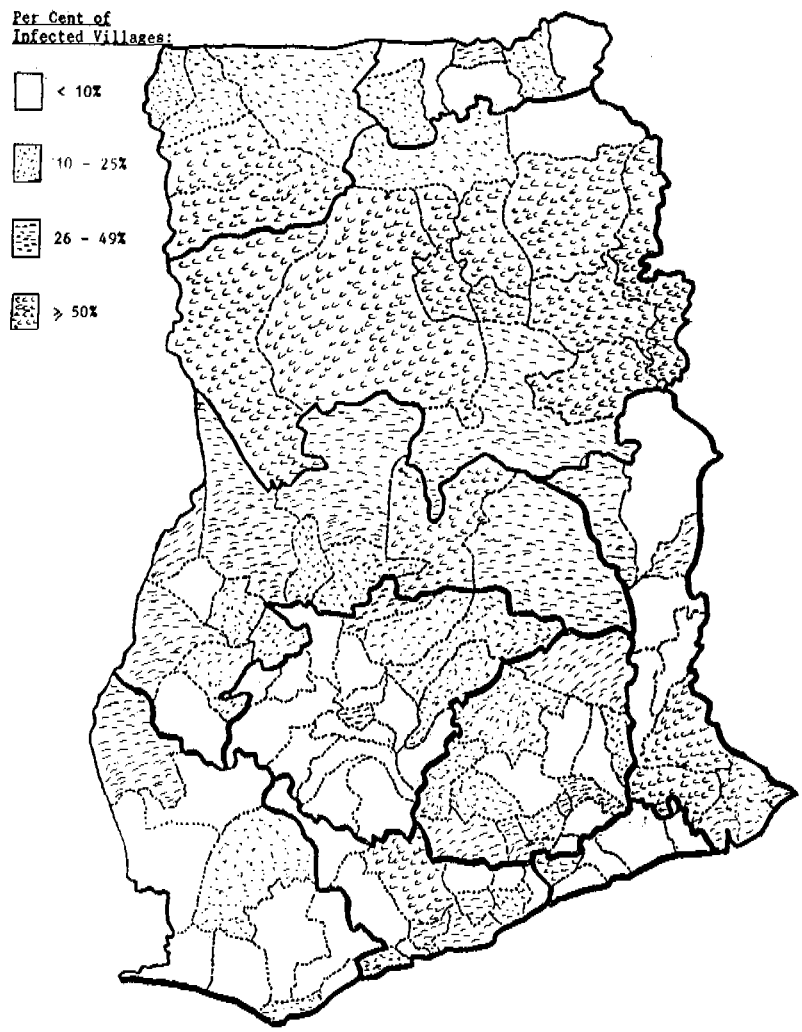
404. The Water and Sanitation Programme will provide services to some 500,000 people living in rural communities of fewer than 500 inhabitants and an additional 120,000 people living in rural communities of between 500 and 5,000 inhabitants. The primary geographic focus of the programme will be on the ten districts selected for convergence of UNICEF-assisted programmes and on Guinea worm-endemic areas as identified in the 1989 National Guinea Worm Search Survey (see map, next page).

Programme Strategy

405. In order to provide the above services, the Water and Sanitation Programme will focus on efforts to increase access to clean drinking water, improve environmental and domestic sanitation as well as personal hygiene in small rural communities. The programme will rely on enhanced community participation, training of district staff and communities, use of appropriate, low-cost and replicable

technologies, expanded use of hygiene education and improved co-ordination among Government agencies and donors.

GHANA
GUINEA WORM ERADICATION PROGRAMME
PER CENT OF GUINEA WORM INFECTED VILLAGES BY DISTRICT
1989 *



* Provisional Data

Complementarity and Linkages

406. The Water and Sanitation programme will be directly supportive of other UNICEF-assisted programmes within the overall Programme of Co-operation, particularly at the regional, district and community levels. At the regional level, the Water and Sanitation Programme will be co-ordinated by the Regional Administration (Planning), which will ensure that Water and Sanitation activities complement other UNICEF-assisted programmes in the areas of Health and Nutrition, Education, Mobilisation and Planning. In addition, a multi-sectoral team

will be established, which will include regional representatives from GWSC, DCD and MOH. This team will help to ensure the complementarity of the water and sanitation activities of all donors. At the district level, the programme will be co-ordinated through a parallel multi-sectoral team which will, in turn, be co-ordinated with other UNICEF-assisted activities through the Social Sector Sub-Committees of the District Assemblies.

Monitoring and Evaluation

407. Monitoring will be conducted in an integrated manner for the two projects within the Water Supply and Sanitation Programme. GWSC, DCD and MOH Field Officers, at the regional and district levels, will have the primary responsibility for monitoring activities, in conjunction with District Assemblies. At the national level, monitoring will be the responsibility of the national agencies (GWSC, MLG/DCD, MOH and UNICEF). The indicators to be monitored at the district and community levels will include the following:

a. the number and functioning of village water and health committees which are established and the number of women serving in these committees;

b. the number of artisans trained for the construction of hand dug wells, boreholes, alternative systems and VIP latrines, and the number of caretakers trained;

c. the number of wells, boreholes and alternative systems constructed or rehabilitated;

d. the number of latrines constructed on communal and household basis;

e. the incidence of water-and exreta-related diseases (Guinea worm, schistosomiasis, cholera and diarrhoea);

f. the extent of involvement of women in the maintenance system; and

g. the number of follow-up health/hygiene education visits/meetings.

408. District technicians will submit reports to heads of GWSC, DCD and MOH at the district level to the District Assemblies who will analyze the above indicators and report on a quarterly basis. One copy of each report will be submitted to the heads of GWSC, DCD and MOH who, in consultation with the District Assemblies, will submit a report on action taken to the Regional Heads, together with a report on the following indicators to be monitored at the regional level:

a. list and number of supplies/equipment;

b. status on training of artisans; and

c. status of: i) health/hygiene education, ii) community mobilisation iii) water supply and sanitation facilities.

409. The above will be analyzed at the regional level and a report submitted to the national level and to UNICEF. UNICEF Programme Officers will follow through this process at all levels to ensure accurate and prompt reporting. A committee comprised of heads of GWSC, DCD and MOH at the national level will analyse the reports and advise on status of rural water and sanitation in the districts.

410. The overall Water and Sanitation Programme will be monitored continuously through field visits, and will be reviewed in joint Government of Ghana/UNICEF Annual Planning and Review Meetings, as well as in a Mid-Term Review planned to take place in 1993. Furthermore, a major evaluation of the programme, tentatively planned for late 1993, will assess the effectiveness of efforts to reach the Government's target of eradicating Guinea worm. The evaluation will also assess the effectiveness of the projects and activities designed to improve water supply and sanitation services for the target population and the impact of these services on the prevalence of water-related diseases. Key indicators to be used in the evaluation will include the extent of reduction of mortality due to diarrhoeal disease and the prevalence of Guinea worm, as reported by the Ministry of Health's regular reporting system, in addition to the operational and monitoring indicators noted above. (See the schedule of evaluations in the Evaluation Project under the Planning, Monitoring and Evaluation Programme).

PROGRAMME BUDGET/TIMEFRAME

(THOUSANDS OF US DOLLARS)

PROJECT/Activities	1991	1992	1993	1994	1995	TOTAL
WATER AND SANITATION						
1. Rural Water Supply	334	553	606	619	543	2655
2. Environ. & Domest. Sanitation	174	180	169	167	83	773
SUBTOTAL	508	733	775	786	626	3428
Programme Support	9	25	11	12	26	83
TOTAL PROGRAMME	517	758	786	798	652	3511
Funding.						
General Resources	298	326	319	277	259	1479
Funded Sup Funding	0	0	0	0	0	0
Unfunded Sup Funding	219	432	467	521	393	2032
TOTAL PROGRAMME	517	758	786	798	652	3511

PROJECT: RURAL WATER SUPPLY (GUINEA WORM ERADICATION)

PROGRAMME SECTOR: WATER SUPPLY AND SANITATION

IMPLEMENTING AND CO-OPERATING ORGANISATIONS:

PRINCIPAL COUNTERPART:	**GWSC; DCD; MOH**
PRINCIPAL DONORS:	**UNICEF**
OTHER AGENCIES:	**UNDP; WORLD BANK; CIDA; KFW; JICA; GLOBAL 2000; WATER AID; WORLD VISION; CHURCH OF CHRIST; OXFAM; ADRA**

PROJECT BUDGET: US$ 2,655,000

OVERVIEW

411. Lack of access to clean water supplies is one of the principal causes of water-related diseases such as acute diarrhoea, Guinea worm and typhoid. All of these diseases are transmitted by either bacteria, viruses or parasites which are prevalent in the unclean and unprotected water sources most frequently used by the inhabitants of small rural villages in Ghana. In the larger urban and peri-urban centres, similar problems exist among the more disadvantaged populations, who do not have access to the urban water supply system. Women and children suffer disproportionately from lack of access to clean water both because they are more vulnerable to the effects of water-related diseases and because they bear the primary burden of collecting water from distant sources for household use.

412. Dracunculiasis (Guinea worm) is a disease which has serious adverse effects on health, agricultural production and school attendance. The disease is contracted by drinking contaminated water from stagnant ponds, dugouts and reservoirs. In the National Case Search for Guinea Worm conducted in 1989 by the Ministry of Health with support from Global 2000, approximately 6,800 out of the 19,500 villages screened were found to be endemic, representing a total of some 180,000 individual cases. The Northern Region is the most Guinea worm endemic area, accounting for 56 percent of all cases. Of the cases detected in the latter Region, 20 percent occurred among children under five, with a high probability of suffering permanent disability, 20 percent among children of primary school age (five to nine years), 20 percent occurred among children and young adults aged nine to 20 years, and 40 percent among adults over 20 years of age.

413. Despite over four decades of efforts on the part of Government to expand potable water supply systems to all parts of Ghana, coverage remains low. Only approximately 49 percent of all Ghanaians have access to clean water. Access also

varies considerably by the population size of settlements, with only 15 percent of those living in communities of less than 500 inhabitants having access to safe water. In communities of between 500 and 5,000 inhabitants, potable water supplies cover approximately 70 percent of the population. Most of the systems installed in rural communities are fragile and subject to frequent breakdowns, in the absence of village-based capacity for maintenance and repair. This situation gives rise to the use of alternative, unsafe water sources, with a consequent high incidence of water-related diseases, particularly Guinea worm.

414. The Rural Water Supply Project will seek to increase rural water coverage from its current level of about 30 percent to approximately 40 percent. The project will accomplish this by focusing primarily on small communities of less than 500 people and, to a lesser extent, on the most disadvantaged sections of larger communities with between 500 and 5,000 inhabitants. This expansion of safe water supplies is intended to first upgrade existing unsafe sources of water, particularly hand dug wells, and, second, to intensify the provision of safe water in Guinea worm endemic communities, thereby contributing to the Government's goal of eradicating Guinea worm by 1993.

PROJECT COVERAGE/TARGETS

415. The Rural Water Supply Project will assist in the rehabilitation and construction of water supply systems to serve approximately 620,000 inhabitants living in small- and medium-sized communities.

PROJECT APPROACH

416. The Project will focus primarily on the construction of hand dug wells fitted with handpumps, drilling and rehabilitation of boreholes, and the development of appropriate technology such as spring boxes, rainwater harvesting systems and filters. Emphasis will be placed on training to expand community participation in the planning, construction and maintenance of village-level systems. In addition, the Project will seek to address the need for improved managerial capacity at the national, regional and district levels to adequately plan and support the expansion of village-level systems.

ACTIVITIES

Community Surveys

417. In order to assess the needs, resources and water potential of the target communities, GWSC, DCD and MOH will jointly carry out surveys of approximately 1,200 communities of fewer than 500 inhabitants each. The studies will assess the existing water supply and sanitation situation, the ground water resources available to each community, the relevant technological solutions, and the capacity of local

leadership to participate in the construction and maintenance of systems. In order to reduce costs and effort, only one survey will be conducted in each community, covering both water supply and sanitation needs. UNICEF will assist GWSC, DCD and MOH in carrying out these surveys by providing funds for transport, subsistence and stationery.

Construction of Hand Dug Wells

418. The project will strongly emphasise the construction of hand dug wells which will not only serve as a low cost technological option but also ensure maximum community participation and maintenance. During the 1991-1995 Programme of Co-operation, 1,600 hand dug wells will be constructed (approximately 320 per year) to provide safe water to 400,000 people in communities with less than 500 inhabitants. The communities themselves will provide labour. GWSC will provide the technical assistance and training required to ensure proper construction and adequate maintenance of the completed wells. The Village/Town Development Committees (Water and Health Sub-Committees) will be responsible for the continuing maintenance of the wells and pumps. Once construction is completed, GWSC will provide chemical agents (chlorine) to disinfect the wells which will then be sealed to prevent subsequent contamination. GWSC will also assist the communities with construction materials such as cement (ten bags of cement per hand dug well) for lining the wells and constructing aprons. UNICEF will provide the tools and equipment for the construction and also assist communities to purchase construction materials.

Construction and Rehabilitation of Boreholes

419. The Project will support the drilling of 120 boreholes and the rehabilitation of another 120 boreholes (approximately 24 of each per year), to provide clean water to a total of 120,000 people living in approximately 200 communities of between 500 and 5,000 inhabitants. All the new and rehabilitated wells will be fitted with handpumps and, where necessary, cement and other materials will be provided for ancillary works (for example, construction of aprons) to be carried out by each community. The drilling unit of the GWSC will co-ordinate the entire activity and will provide, inter alia, all necessary personnel, allowances and disinfection chemicals. GWSC will also train the village handpumps caretakers to ensure continuous operation of the pumps. UNICEF will provide funds to procure spares to rehabilitate the drilling rig to be used by GWSC for drilling and re-drilling boreholes. UNICEF will also support procurement of other drilling supplies, as necessary.

Promotion of Low-Cost Appropriate Technologies

420. Because appropriate technologies such as spring boxes, rainwater harvesting systems, infiltration galleries and filters used in individual households are often much cheaper than the construction of wells, the Rural Water Supply Project will

promote the development of these systems in some communities to be selected following the completion of the community surveys. An estimated 20 communities (approximately four per year) with a total population of about 10,000 will be selected, based on the hydro-geological resources available, and appropriate systems will be designed to make maximum use of those resources to provide clean water at minimum cost. UNICEF will provide tools and materials (for example, cement and pipes) which the communities will require to carry out the construction of these systems under the supervision of GWSC and DCD.

421. In collaboration with the MOH and Global 2000, filters and chemical agents will be purchased and distributed to areas where there is no access to safe water from wells or other sources. Cloth filters will also be provided and promoted for use by farm workers in the fields, who currently rely on stagnant and contaminated water for drinking purposes. In individual households, the construction of larger, more efficient filters (using sand, charcoal and gravel) will be promoted. In addition, chemicals such as Abate will be provided by MOH for the treatment of communal water sources where the construction of wells or other safe water sources has not yet taken place. UNICEF will provide support for transport and subsistence for MOH staff who will visit all endemic communities to promote the use of filters, train community members to build household filters, apply chemicals to existing water supplies and train members of the Village/Town Development Committees (Water and Health Sub-Committees) to apply chemicals on an on-going basis.

Establishment of Effective Surveillance

422. In order to ensure proper reporting of new cases of Guinea worm and to track progress in eradicating the disease, the Project will support regular visits by MOH staff to all endemic villages. On the basis of these visits, reports will be prepared for submission to district, regional and national levels of the MOH. UNICEF will provide assistance in the form of transport, subsistence and stationery supplies for district and zonal level staff who will actually carry out the visits.

Training

423. Training and orientation will be geared towards the development of local artisans at the community level for the construction and maintenance of village water supply and sanitation systems. The Rural Water Supply Project will provide training materials, transport and subsistence for GWSC and DCD staff as well as community members. The Project will train 10,000 local artisans over the five year period to construct hand dug wells, water supply systems based on appropriate technology and KVIP and household latrines. Training will also be provided for approximately 3,680 community handpump caretakers (two caretakers per system) who will be responsible for on-going maintenance of the systems once they are constructed. Village Level Operations and Maintenance (VLOM) pumps will be installed and user fees will be charged at a level to be determined by the Village

Health Water Committees. Specific attention will be given to ensuring that at least one of the two caretakers for each system is a woman.

424. Training and orientation will also be provided to ministry staff at the national, regional and district levels to improve project planning, management and monitoring. Training will include workshops for six project managers at the national level (two each from GWSC, DCD and MOH) and for 30 regional project co-ordinators (one each from GWSC, DCD and MOH in each of the ten regions) and 30 project supervisors at the district level. UNICEF will support travel, subsistence and stationery costs related to these training and orientation courses.

Social Mobilisation and Community Animation

425. Support will be provided to the Department of Community Development (DCD) and the MOH for the preparation of simple educational materials (pamphlets, posters, pictorial leaflets) in local languages, on the prevention of water-related diseases. These messages will be targeted to community leaders and users of rural water facilities and will emphasise the promotion of safe water to combat Guinea worm and diarrhoeal diseases. In addition, a training video on village-based maintenance of handpumps will be produced for use at the community level. UNICEF will support the development of written materials and posters, production and reproduction of videos and the preparation of radio scripts.

MONITORING

426. As noted under the Programme Overview, the staff of GWSC, DCD and MOH at the district, regional and national levels will monitor project inputs and outputs for both the projects in the Water and Sanitation Programme. UNICEF staff will also conduct periodic visits. These monitoring reports will feed into the joint Government/UNICEF Annual Planning and Review Meetings and into the Mid-Term Review planned for 1993. Indicators to be monitored will be as noted in the Programme Overview, with emphasis given to data collected through existing routine monitoring system of the GWSC.

427. The decline of Guinea worm cases will be monitored primarily through the reports on the incidence of Guinea worm submitted by MOH staff visiting each of the 6,800 endemic villages. In addition, Global 2000 will be monitoring the progress of the Government's Guinea Worm Eradication Programme and will share these reports with UNICEF as well as other implementing agencies and donors. UNICEF staff will make periodic visits to endemic villages to observe on implementation, and the results of all these monitoring activities will be fed into Government/ UNICEF Annual Planning and Review Meetings and the Mid-Term Review.

MANAGEMENT OF THE PROJECT

428. Engineers and technicians from the GWSC (Rural Water Division), DCD and MOH and relevant NGOs, supported by the District Assemblies, will assist in the construction of hand dug wells. Two teams will be supported in each region, to supervise the construction of hand dug wells and VIP latrines (under the Sanitation Project). Drilling and rehabilitation of new and old wells will be undertaken by the GWSC Drilling Unit based in Kumasi. It is not intended that each of these units will provide inputs independently but, rather, that they will integrate them within the framework of the water and sanitation programme.

LINKAGES/CONVERGENCE

429. The Rural Water Supply Project will be closely linked with the Environmental and Domestic Sanitation Project, particularly in the areas of community surveys and training. The same DCD and MOH staff will work on both the projects. The project will also address the issue of iodine deficiency that gives rise to goitre and will therefore be linked with the Control of Iodine Deficiency Disorders (water iodisation) Project under the Health and Nutrition Programme.

GOVERNMENT CONTRIBUTION

430. During 1991-1995, the Government will allocate an equivalent of US$ 619,790 to the cost of staff, materials and training, as noted above, in addition to regular expenditures in the sector.

PROJECT INPUTS

431. UNICEF will support the cost of the following project inputs, to the extent available financing permits:

Inputs	1991	1992	1993	1994	1995	Total
Rural Water Supply (Guinea Worm Eradication)						
Community Surveys	1	0	0	0	0	1
Hand dug well construction equipment-sets	5	9	15	0	0	29
Hand pumps	120	461	507	490	510	2088
Vehicles (4-wheel drive)	1	1	0	0	0	2
Packages of drilling parts & supplies	4	3	5	5	4	21
A complete rig repair workshop	1	0	0	0	0	1
Truck (20 ton)	1	1	0	0	0	2
Set of alternative technology materials	0	0	0	50	60	110
Planning / training sessions:						
- national level	1	1	1	1	1	5
- district level	1	1	1	1	1	5
Training sessions for:						
- 4,800 local artisans (10 days)	48	48	48	48	48	240
- 3,600 community handpump caretakers	40	40	40	0	0	120

PROJECT BUDGET

(THOUSANDS OF US DOLLARS)

PROJECT/Activities	1991	1992	1993	1994	1995	TOTAL
1. Rural Water Supply (Dracunculiasis Eradication)						
Community surveys	10	0	0	0	0	10
Construction of hand dug wells	87	325	392	368	274	1446
Construction and rehabilitation of boreholes	122	91	82	80	64	439
Promotion of low cost alternative technologies	20	23	23	71	90	227
Training	54	54	54	35	35	232
Com. and Social mobilisation	31	40	35	30	40	176
Surveillance	10	20	20	35	40	125
PROJECT TOTAL	334	553	606	619	543	2655
Funding.						
General Resources	158	229	232	190	196	1005
Funded Sup Funding	0	0	0	0	0	0
Unfunded Sup Funding	176	324	374	429	347	1650
PROJECT TOTAL	334	553	606	619	543	2655

PROJECT: ENVIRONMENTAL AND DOMESTIC SANITATION

PROGRAMME SECTOR: WATER SUPPLY AND SANITATION

IMPLEMENTING AND CO-OPERATING ORGANISATIONS:

PRINCIPAL COUNTERPART:	**MOH; DCD; GWSC**
PRINCIPAL DONORS:	**UNICEF**
OTHER AGENCIES:	**UNDP; WORLD BANK; CIDA; KFW; JICA; WATER AID; WORLD VISION; CHURCH OF CHRIST; OXFAM; ADRA**

PROJECT BUDGET: US$ 773,000

OVERVIEW

432. The absence of adequate sanitation facilities in rural communities is a major contributor to acute diarrhoea, malaria, typhoid and other excreta- and water-related diseases. The cycle begins with an individual ingesting a parasite or other organism and then passing on its eggs or larvae through defaecation in the open. The latter practice together with the lack of adequate drainage breeds disease carriers such as mosquitoes and flies and pollutes sources of water supply.

433. Only about 15 percent of the rural population has access to good sanitary facilities. This problem is particularly acute in small villages of fewer than 500 inhabitants where sanitary facilities are virtually non-existent and open defaecation is common practice. Due to the lack of infrastructure, these villages are also more likely to have inadequate drainage facilities, thus compounding the problem of disease transmission. Lack of knowledge concerning proper personal hygiene and environmental sanitation, and the links between these and diarrhoeal and associated diseases, is another major contributing factor to disease transmission.

434. Previous efforts to promote the use of Kumasi Ventilated Improved Pit (KVIP) latrines have been constrained by the lack of resources at the community level. As originally designed, the KVIP units were meant to be built using locally available materials. However, greater reliance was eventually placed on external materials as they were competitive in price at that time. With the advent of economic crisis in the early 1980s, the price of external materials became unaffordable for most communities.

435. The Environmental and Domestic Sanitation Project will seek to increase rural sanitation coverage from the present level of 15 percent to approximately 25 percent, with a primary focus on villages with fewer than 500 inhabitants. The Project will focus exclusively on the construction of sanitation facilities and in

conjunction with the Mobilisation Programme and the Department of Community Development, the improvement of knowledge and practices related to personal hygiene and sanitation.

COVERAGE/TARGETS

436. The Project will promote domestic and community sanitation facilities for approximately 620,000 people living in rural communities.

PROJECT APPROACH

437. The Project will focus on the construction of 1,200 communal and household demonstration units to directly serve approximately 60,000 people. These units will be used to show how proper sanitary facilities can be constructed at low cost and using locally available materials. Support will be provided to facilitate their replication in the area comprising the entire target population. In addition, an assessment of community refuse disposal practices will be made and support will be given to communities for the improvement of their immediate environment.

ACTIVITIES

Support/Establish Sanitation Construction Centres

438. In order to assure an adequate supply of cement slabs which are the basic component of VIP latrines, UNICEF will support the establishment or strengthening of ten model construction centres, one in each region. Each centre will be supervised by the regional office of the DCD and will provide all the slabs required by the Sanitation Project in the region. In addition, the centres will train community artisans to construct slabs on their own. UNICEF support will consist of a one-time infusion of seed capital to purchase the required construction materials and tools for each centre. Once production begins, the centres will be funded from the sale of slabs to communities, thus assuring the sustainability of the project.

Construction of Demonstration Units

439. Based on the community surveys to be carried out under the Rural Water Supply Project (see above), a number of communities will be identified for the installation of 800 household and 400 communal KVIP latrines (approximately 160 and 80 per year, respectively). Construction techniques will stress the use of low-cost locally available materials and labour. The cement slabs required will be provided by the Construction Centres (see preceding paragraph) and paid for by the communities. It is expected that, by showing how improved sanitation can be provided at low cost, the demonstration units will stimulate replication by others in the target communities as well as leaders of other communities. Training of community artisans and caretakers will be carried out in conjunction with the Rural

Water Supply Project. UNICEF will cover the travel and subsistence costs of DCD staff and trainers who will assist in the construction of the demonstration units.

Support for Refuse Disposal and Drainage

440. Based on the surveys to be carried out under the Rural Water Supply Project, an assessment will be made of community needs in the area of waste disposal as well as the most appropriate remedial actions. Following the assessment, communities will be assisted to design and implement waste collection and disposal systems, in order to help improve environmental and domestic sanitation. UNICEF support will consist primarily of technical assistance to DCD and MOH staff and trainers at the district level. In addition, limited assistance, in the form of supplies and materials, will be provided to communities.

Social Mobilisation and Animation

441. Support will be provided to the DCD and the MOH for the preparation of simple educational materials and radio programmes in local languages on the risk of unhygienic practices. These materials will be targeted at community leaders and the users of sanitary facilities.

LINKAGES/CONVERGENCE

442. The Environmental and Domestic Sanitation Project will be closely linked with the Water Supply Project, particularly in the areas of community surveys and training. Both Projects will also rely on the DCD and MOH staff at the district and regional levels.

MONITORING

443. As noted under the Programme overview, the staff of GWSC, DCD and MOH at the district, regional and national levels will monitor project inputs and outputs for both Projects in the Water and Sanitation Programme. These monitoring reports will feed into the joint Government/UNICEF Annual Planning and Review Meetings and into the Mid-Term Review planned for 1993. Indicators to be used will be as noted in the Programme Overview, with emphasis on data collected by GWSC through its existing routine reporting systems.

GOVERNMENT CONTRIBUTION

444. During 1991-1995, the Government will allocate an equivalent of US$ 473,000 to the cost of staff, materials and training, as noted above, in addition to regular expenditures in the sector.

PROJECT INPUTS

445. UNICEF will support the cost of the following project inputs, to the extent available financing permits:

Inputs	1991	1992	1993	1994	1995	Total
Environmental and Domestic Sanitation						
Bags of 50 Kg cement	3000	3000	3000	1000	1000	11000
Roofing sheets -10 pkts of 22 sts/centre	60	60	60	20	20	220
Reinforcement iron bars (50 tons/	300	300	300	100	100	1100
Bags of 50 Kg cement com. latrines	0	1000	1000	1000	500	3500

PROJECT BUDGET

(THOUSANDS OF US DOLLARS)

PROJECT/Activities	1991	1992	1993	1994	1995	TOTAL
2. Envirn. & Domestic Sanitation						
Sanitation construction centres	62	90	78	92	8	330
Construction of Demo units	75	55	56	50	50	286
Refuse disposal and drainage	20	15	15	10	10	70
Com. and social mobilisation	17	20	20	15	15	87
PROJECT TOTAL	174	180	169	167	83	773
Funding.						
General Resources	131	72	76	75	37	391
Funded Sup Funding	0	0	0	0	0	0
Unfunded Sup Funding	43	108	93	92	46	382
PROJECT TOTAL	174	180	169	167	83	773

SOCIAL MOBILISATION PROGRAMME

SUMMARY

446. The 1991-1995 Programme of Co-operation seeks to reduce the U5MR through the delivery of basic services in health, nutrition, water and sanitation and education. Experience over the years has, however, shown that the increased availability of such services has to be matched with higher utilisation in order to lead to a reduction in mortality. The success of the new Programme of Co-operation will, therefore, depend, to a significant extent on the creation of demand for basic services.

447. The Social Mobilisation Programme aims to ensure effective utilisation of basic services by improving the knowledge, attitudes and practices (KAP) of the population, especially women, with respect to basic preventive health measures and Primary Health Care (PHC) interventions. In addition, the mobilisation process will help to ensure the sustainability of the Programme of Co-operation by generating commitment at all levels to the development and maintenance of basic services.

448. On the basis of past experience, communities will be mobilised through more effective use of the Social Mobilisation Committees for Child Survival and Development (SMCCSD). Emphasis will be placed on group and inter-personal communication, the supply of communication materials and increased coverage of CSD and women-related issues by the print and electronic media. In this respect, CSD committees will be strengthened at all levels and will, in turn, complement the work of Village Health Committees (VHCs), which form the basic institutional unit of the mobilisation structure. Attempts will be made to strengthen and expand the social mobilisation and education capacity of the print and electronic media. At the same time, efforts will be made to improve the capacity of both the Audio Visual Section of the Department of Community Development (Ministry of Local Government) and the Health Education Division (HED) of the Ministry of Health (MOH), to design, pretest and produce visual aids.

BACKGROUND

449. At the family and community levels, there is a general lack of essential knowledge concerning child and maternal health. This is because these vital health messages have not been communicated in a manner and intensity sufficient to break through society's diverse cultural, linguistic, religious and economic barriers.

450. Religious beliefs lead people to attribute both the birth and death of children to the will of God. This tendency has implications for solutions to health problems. If diseases are explained away in spiritual terms, then nutritious food, drugs and safe drinking water become secondary considerations in the solution of health problems.

451. Certain cultural taboos and values militate against the mother and child in Ghana. For instance, when the child is born, it may be denied the rich, nutritious colostrum from the mother's breast in certain communities because of the belief that if this rich yellowish milk is given to the child, its head will become big and ugly. In some communities, children are denied eggs because of the belief that they will become thieves if they are given eggs and meat and cannot afford them when they grow up. In the area of fertility, there are numerous pronatalist beliefs which impede birth spacing and family planning. For example, it is believed that a women who has given birth to triplets should reduce her enlarged women by subsequently giving birth to twins and then to a single child.

452. Ignorance or insufficient awareness also contributes to lqw utilisation of health facilities and services. A UNICEF study on knowledge, attitudes and practices (KAP) in 1988 showed that, whereas 96 percent of mothers had heard about immunisation, only 18 percent knew that five contacts were required for a full course of vaccinations.

453. Non-conventional modes of communication constitute the most significant channel of communication. These include traditional and religious leaders, public address systems, drama, gong-gong beaters, herbalists and drug sellers. In terms of more formal communications structures, radio covers the entire country and is accessible to nearly 60 percent of the population, although such access is heavily concentrated in urban areas. Television coverage theoretically extends over 80 percent of the national territory, however the ratio of television sets per household is only 1:0.08, or approximately one television set per 621 people. The coverage of both radio and television is, in reality, somewhat larger than these low ratios would indicate due to a practice whereby many radio and television owners frequently allow neighbours to have access to their radios and televisions. With the easing of restrictions on the importation of radios and televisions in recent years, the numbers of sets available in the country has begun to rise, although it will be some time before the full potential of these services can be realised.

454. The newspaper circulation figures for the two national daily newspapers, the People's Daily Graphic and Ghanaian Times, are 130,000 and 100,000 respectively. Together, the two dailies have a coverage of 0.1 newspapers per household, which is very low. A content analysis of these newspapers showed low coverage of health and child related issues. This is due to journalists' lack of knowledge about the issues involved.

455. The Ministry of Mobilisation and Social Welfare (MM&SW) is the principal institution responsible for social mobilisation in the country. It aims to: mobilise society for the promotion of child health, protection and development through awareness creation; establish functioning mobilisation structures especially at the zonal/community levels in each district; and co-ordinate mobilisation activities at all levels.

456. At the national level, the National Social Mobilisation Committee on Child Survival and Development (NSMCCSD) has been established with its secretariat within MM&SW. The NSMCCSD is composed of relevant Government ministries and/or departments, NGOs, religious organisations and the trade unions.

457. The Committee functions through three standing sub-committees namely, Communication Support, Outreach and Resources and Logistics Mobilisation. The NSMCCSD is replicated at the regional and district levels, under the Regional and District Administrations. Overall supervision is provided by MM&SW.

458. Despite recent progress, there are still a number of problems in the social mobilisation sector. First, co-ordination within the mobilisation structure at the regional and district levels is still weak. Second, the mobilisation committees at the sub-national levels, especially in Brong Ahafo and the Northern, Upper East and Upper West Regions, are seriously constrained by a lack of mobility. Third, few analyses have been made in Ghana examining social communication in, for example, agriculture, health and the environment. Finally, social mobilisation activities are not being adequately monitored or evaluated.

PAST CO-OPERATION

459. Between 1986 and 1988, UNICEF assistance in the area of social mobilisation was provided on an ad hoc basis, without any attempt to co-ordinate the efforts of isolated institutions and groups. The primary aim of mobilisation efforts was to support the Expanded Programme on Immunisation (EPI). The most successful efforts were made in the Greater Accra Region, where the Regional Health Administration organised a mobilisation task force to plan, implement and monitor the mobilisation component of the EPI programme.

460. The experience with EPI and the First Earth Run (in 1986), through which thousands of people throughout Ghana were sensitised on children's issues, convincingly demonstrated the potential of social mobilisation as a support function of the Government of Ghana/UNICEF Programme of Co-operation and other national programmes. In order to make greater use of this potential, an intensified drive was initiated beginning in early 1988 so as to ensure that regional authorities were sufficiently sensitised on the role they could play in ensuring the delivery of integrated interventions in CSD and in spearheading efforts to achieve Universal Child Immunisation (UCI). This intensification of social mobilisation efforts was based, to a large extent on the outcome of a social mobilisation study which sought to:

a. Identify individuals, institutions and organisations in both rural and urban communities with the greatest potential as health communicators;

b. Assess the kind of support needed by individuals, institutions and organisations to maximise their potential as health communicators; and

c. Identify the means with which to build a partnership between various groups and the public health services, in order to educate and mobilise communities, on a continuous basis on the promotion of child and maternal health.

461. The study showed that many institutions and organisations in Ghana had the potential to serve as allies for CSD but had not previously been mobilised and were not aware of their potential roles. In addition, it indicated that the mass media, besides having a low level of knowledge of children's issues, were not being used to their maximum potential. Finally, the study suggested that inter-personal communication at the community level could be very effective if groups such the CDRs, teachers and religious leaders were sufficiently equipped with information on CSD.

462. Based on these results, a National Social Mobilisation Committee for Child Survival and Development (NSMCCSD) was created May 1989, under the auspices of the Ministry of Mobilisation and Social Welfare (MM&SW) . As a first step, an EPI Communication Plan was formulated. The NSMCCSD had notable success in stimulating commitment by the Government at the highest levels to achieve UCI by 1990, and assisted in the formulation of regional strategies to utilise CSD committees for the attainment of that goal.

PROPOSED PROGRAMME

463. The Mobilisation Programme will serve a critical support function within the 1991-1995 Programme of Co-operation. It is intended to create and sustain a process of social change with respect to knowledge, attitudes and practices on health (including EPI/ORT, ARI, Safe Motherhood and AIDS), nutrition, women issues and child rights, in order to ensure the sustainability of all sector programmes. The Programme will undertake to mobilise leaders at all levels of society in support of Child Survival and Development and will also provide the materials and communication support services required by each project.

464. Overall, the Social Mobilisation Programme will have the following four objectives:

a. Increased recognition of the importance of Child Survival issues and Child Rights;

b. Increased recognition of the role and importance of women;

c. Increased demand for essential health, nutrition, water and sanitation and education services;

d. Increased community participation in the planning and implementation of these services; and

e. Through information dissemination, empowerment of communities to take care of their own welfare.

PROGRAMME STRATEGY

465. The emphasis of the Programme will be on strengthening the capacity of CSD committees at all levels to undertake effective programme delivery. Functioning CSD committees will ensure the mobilisation of resources, both human and financial, to support the country programme objectives. The Programme will also use the Social Mobilisation Committees on CSD to mobilise leaders, allies, the media and communities in support of activities designed to improve the situation of women and children in Ghana. It will provide the necessary materials to accomplish this objective, with respect to each UNICEF-assisted programme and project.

Geographic Coverage and Target Population

466. To achieve its objective, the programme aims at reaching children and women throughout the country but with special emphasis on the ten districts selected for convergence of services.

Complementarity and Linkages

467. The Programme's supportive function cuts across all other programmes. It will help to achieve and sustain high levels of utilisation of the basic services delivered through the new Programme of Co-operation. It will also help ensure sustainability and foster a sense of ownership on the part of the Government and people regarding the new Programme of Co-operation.

Monitoring and Evaluation

468. The impact of the programme will be evaluated through changes in the knowledge, attitudes and practices of the target population, as assessed through KAP studies and indicated by demand for the services provided by UNICEF-assisted projects.

PROGRAMME BUDGET/TIMEFRAME

(THOUSANDS OF US DOLLARS)

PROJECT/Activities	1991	1992	1993	1994	1995	TOTAL
MOBILISATION						
1. Advocacy & Mobilisation	165	199	198	172	169	903
2. Mass Media Development	75	101	42	18	25	261
SUBTOTAL	240	300	240	190	194	1164
Programme Support	20	25	30	35	31	141
TOTAL PROGRAMME	260	325	270	225	225	1305
Funding.						
General Resources	260	325	270	225	225	1305
Funded Sup Funding	0	0	0	0	0	0
Unfunded Sup Funding	0	0	0	0	0	0
TOTAL PROGRAMME	260	325	270	225	225	1305

PROJECT: ADVOCACY AND MOBILISATION OF ALLIES

PROGRAMME SECTOR: SOCIAL MOBILISATION

IMPLEMENTING AND CO-OPERATING AGENCIES:

PRINCIPAL COUNTERPART:	**MM&SW**
PRINCIPAL DONOR:	**UNICEF**
CO-OPERATING AGENCIES:	**MOH, MOI, NCWD, GNCC**

PROJECT BUDGET: **US$ 903,000**

OVERVIEW

469. Political, administrative and traditional leaders have little knowledge about the state of women and children in Ghana or of the efforts being made by the international community to advance the concerns of these two vulnerable groups. Due to this lack of knowledge, they tend to be slow in instituting policies and measures which can improve the status of women and children.

470. In order to address this problem, the Ministry of Mobilisation and Social Welfare launched a National Social Mobilisation Committee for Child Survival and Development (NSMCCSD), with representatives drawn from all Government ministries and non-governmental bodies whose activities affect the social sector: the MOH, MOA, MFEP, MLG, MOI, NCWD, GNCC, representatives of revolutionary organs such as the 31st December Women's Movement and CDRs as well as the major mass media (GBC, Ghanaian Times, Daily Graphic) and trade unions. The WHO and UNICEF participate as donor agencies. The NSMCCSD meets every two weeks to assess progress and discuss problems related to national social mobilisation efforts. It is noteworthy that a majority of the members of the NSMCCSD are women.

471. In addition to the NSMCCSD at the national level, regional and district committees have been established under the leadership of the PNDC Regional and District Secretaries. In all, 121 Social Mobilisation Committees for Child Survival and Development are now functioning throughout the country (one national, ten regional and 110 district committees). At each level, the SMCCSD co-ordinate all mobilisation efforts related to the welfare of children, for example EPI/ORT, Guinea worm, AIDS and the release of the annual UNICEF State of the World's Children Report.

472. In order to enable the SMCCSD to expand their outreach and influence, the Advocacy and Mobilisation of Allies Project will provide institutional support as well as orientation and training to CSD committees at all levels. Special emphasis will be placed on ensuring that committee members are fully conversant with the "Facts for

Life" messages and are sensitised to the roles and needs of women. The SMCCSD will serve as key actors in all other projects within the Mobilisation Programme.

473. The Secretariat of the NSMCCSD will prepare background materials for distribution at these meetings and participants at each level will be expected to serve as resource persons to the next lower level. In addition, two day orientations for the secretaries of the national, regional and district SMCCSDs will be conducted focusing on planning, implementation and monitoring of programmes. UNICEF inputs to these activities will include support towards the preparation of background materials and assistance with transport, subsistence and stationery cost.

PROJECT COVERAGE/TARGETS

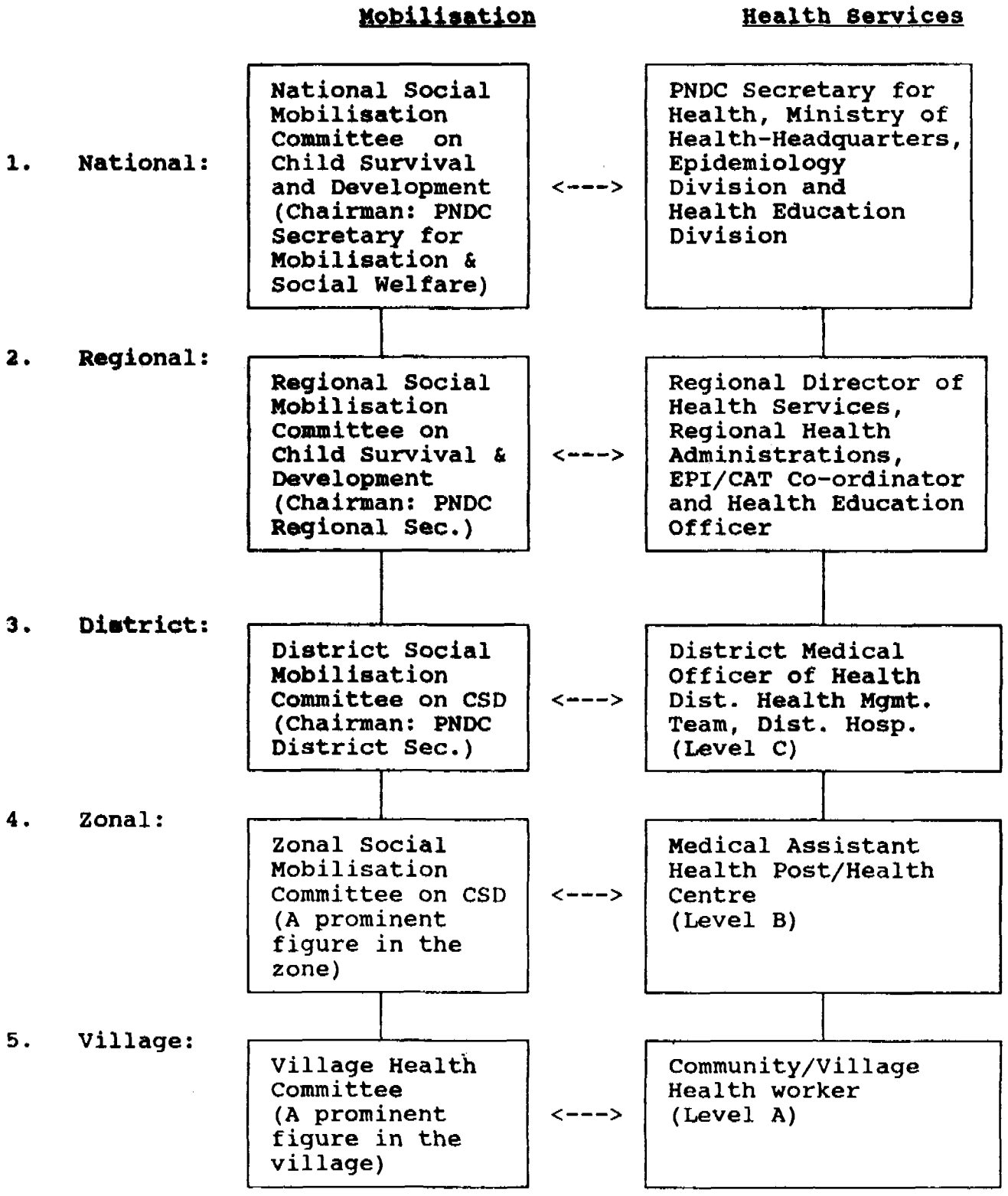
474. The project will carry out advocacy on children's and women's issues with approximately 50,000 people made up of national, regional, district and local leaders including Provisional National Defence Council (PNDC) members, PNDC Secretaries (ministers), senior Government officials, traditional leaders (chiefs), Muslim and Christian Leaders and selected NGOs.

475. The project is further designed to raise the operational efficiency, improve the management and strengthen the co-ordinating role of the 121 Committees on CSD at the national, regional and district levels.

PROJECT APPROACH

476. The project seeks to utilise the institutional structure of the SMCCSDs to mobilise allies for the continuous involvement of communities in their own development. In order to do this, there is a need to strengthen both the technical knowledge and material base of the SMCCSDs. This will be done through seminars/ orientations and the provision of inputs to enhance their delivery capacity. The materials to be used in this project will include those produced through other UNICEF-assisted projects, particularly the Non-Formal Education and Life Skills in Primary School projects.

Social Mobilisation Infrastructure for CSD



ACTIVITIES

Institutional Support

477. The Project will assist in strengthening or setting up well-equipped secretariats for SMCCSDs at all levels, to manage activities under the various projects in the Mobilisation Programme. UNICEF inputs will include bicycles, motorbikes, office equipment and stationery.

478. Annual review and strategy formulation meetings, each lasting two days, will be held by the CSD committees at the national, regional and district levels. Meetings at each of the lower levels will normally precede the meetings at the next higher level and a representative from each meeting will participate in the meeting at the next higher level. In addition, supervisory visits to each region will be carried out by the members of the NSMCCSD assigned to specific regions. UNICEF will support the costs of transport, subsistence and stationery related to all these meetings.

Advocacy and Mobilisation Through Involvement of Allies

479. The NSMCCSD will plan and organise for the continuous and active involvement of six identified groups namely schools, religious and traditional leaders, revolutionary organs, the Ghana Private Road Transport Union (GPRTU), District Assemblies and extension workers in CSD activities at the national, regional and district levels.

480. In primary schools, emphasis will be placed on promoting a child-to-child approach which will lead to the active involvement of children in health-related activities. In addition, CSD clubs will be established in secondary schools by the district SMCCSD and the Ministry of Education (MOE). UNICEF inputs will consist of project support communication materials produced under other programmes/projects, including those developed by the Non-Formal Education project. Other reading materials on Life Skills will be provided through the Life Skills in Primary School.

481. To ensure the active involvement of religious and traditional leaders in CSD activities, 50 religious and traditional rulers in each district will be orientated through annual seminars on different topics. These seminars will be organised by the district SMCCSD in collaboration with the National Commission on Culture (NCC). Through the Non-Formal Education project, adaptations of "Facts for Life" will be provided to participants.

482. In collaboration with the Non-Formal Education project, each district SMCCSD will carry out training and orientation sessions for revolutionary organs such as the 31st December Women's Movement, the Committees for the Defence of the Revolution (CDRs) and the Civil Defence Organisations (CDOs), to better equip

them as disseminators of essential information related to the welfare of women and children. Each training and orientation session will last one day and will involve an average of 50 participants, supported with materials produced under other sector programmes. Furthermore, with the collaboration of the Non-Formal Education project, orientation seminars lasting a day will take place in all the 110 districts (22 districts annually). Each seminar will have approximately 50 participants and will aim to expand their knowledge and improve their ability to communicate effectively on CSD issues. The workshops will involve a total of approximately 1,100 participants per year. This activity will specifically aim to improve the communications skills of extension workers at the district level who come into direct contact with the target population, including staff from the MOH, MOA, GWSC and DCD.

483. Focusing on the 110 Districts in the country, annual orientation and training seminars will be organised in each region by the regional SMCCSDs for members of the Social Sector Sub-Committees of each District Assembly. Each seminar will consist of two to three days of discussions on different topics related to CSD, women's issues, and the Convention on the Rights of the Child, among others with a specific focus on the role that District Assemblies can play in improving the situation of women and children in their respective areas. Furthermore, each District Assembly will be encouraged to produce a report on the actuation of children and women in its area. UNICEF inputs will include materials and assistance with stationery, transportation and subsistence.

484. Long distance buses of the GPRTU will be provided with pre-recorded audio cassettes consisting of music interspersed with messages on child survival and development. Regional SMCCSDs will distribute the cassettes together with information leaflets to the drivers and conductors of GPRTU vehicles who will, in turn, be encouraged to distribute them to the members of their committees. In addition, the GPRTU representative on the regional SMCCSD will facilitate the distribution of signs and stickers on CSD and other social development-related initiatives for display by at least 60 percent of GPRTU vehicles. UNICEF inputs will include support for the production of the pre-recorded cassettes, leaflets, signs and stickers.

485. Each year, the national SMCCSD, in collaboration with the Ghana National Commission on Children (GNCC) and the National Council on Women and Development (NCWD), will organise a seminar for policy-makers on a topical issue affecting women and children at the national level. UNICEF will assist with the preparation of documents and the production of a video on each year's topic as well as bear the cost of printing reports.

486.In each region, an annual workshop on topics related to enhancing the role of women will be held under the auspices of Regional SMCCSDs with the active involvement of the NCWD and the 31st December Women's Movement. Each workshop will involve approximately 60 participants, including local leaders and

representatives from various organisations such as women's groups, revolutionary organs and trade unions. UNICEF will assist with the preparation of background materials and the organisation of the workshops.

487. Each year the GNCC, in collaboration with UNICEF, will launch the UNICEF State of the World's Children's Report (SOWCR). The launch will be linked with the annual "Child Survival and Development Week" organised by the SMCCSDs at the national, regional, district and sub-district levels. The week of activities (which include durbars, seminars and environmental clean up campaigns) has, as its theme, the major topics highlighted in each SOWCR. UNICEF will provide the SOWCR and will support the publicity programme for the week.

Publications

488. The national SMCCSD will produce a quarterly newsletter on CSD issues and activities for distribution to all SMCCSDs. This publication will provide news on the latest initiatives and activities in Ghana related to CSD and will assist the national SMCCSD in motivating and co-ordinating the activities of the regional and district SMCCSDs. Each quarter, 3,000 copies of the newsletter will be produced by the secretariat of the national SMCCSD. UNICEF will provide the necessary newsprint while the national SMCCSD will provide all editorial and design inputs.

489. All Unit Committees will be equipped with a simple handbook on CSD to be developed by the Health Education Unit of the MOH in collaboration with the national SMCCSD. A total of 15,000 handbooks will be produced.

490. The Ghana National Commission on Children, with assistance from UNICEF, will co-ordinate the production of a simplified version of the Convention on the Rights of the Child. Which will be translated into six local languages. These translations will form the basis for discussions at annual regional workshops for 60 traditional leaders and rulers per region. The workshops will be supported by UNICEF.

491. Each year, the National Council on Women and Development and the Ghana Association for Women's Welfare will focus on two regions, to study and analyze traditional customs and practices that are detrimental to women. The results of this study will be published in booklets and 5,000 copies will be printed for general distribution and for use as inputs to workshops on women's issues. UNICEF will assist with the editing, design and reproduction of the booklets.

Information, Education & Communications (IE&C) on AIDS/HIV

492. AIDS will become a major issue on the agenda of CSD committees at all levels. In order to stimulate action by the committees, the first orientation seminars for all committees will have AIDS as one of the major issues for discussion.

493. In order to influence decision-makers and, thus, Government policy, a quarterly circular will be issued to all PNDC Secretaries, Heads of Government organisations and NGOs as well as community and church leaders, on the magnitude and distribution of AIDS/HIV by region and district.

494. A Supplementary Reader on AIDS will be produced for use in primary schools and Junior Secondary Schools and 40,000 copies will be distributed. In addition, three sets of leaflets of 100,000 copies each will be produced, targeted at the general public, schools and adolescents. Finally, 25,000 posters will also be produced and distributed during the period.

MONITORING

495. Activity outputs will be monitored through the submission of monthly reports by district SMCCSDs to the regions, and quarterly reports by the regional SMCCSDs to the national SMCCSD. In addition, participation in programmes and field trips and reports by the GNCC and NCWD will be monitored. Key indicators will include the number of meetings and seminars actually held, the number of participants and the numbers of materials such as posters, pamphlets actually produced and distributed.

MANAGEMENT OF THE PROJECT

496. The national SMCCSD will provide the framework for sustaining the advocacy and mobilisation initiatives of the GNCC, NCWD and other organisations including relevant NGOs, and will oversee the implementation of all activities within the Project. The national SMCCSD will supervise the regional SMCCSDs who will, in turn, supervise district level SMCCSDs.

LINKAGES/CONVERGENCE

497. This Project represents the core of the Social Mobilisation Programme. It will permit the continuous mobilisation of allies, policy-makers and opinion-leaders and ensure their sustained involvement in CSD and women-related activities.

OPPORTUNITIES/CONSTRAINTS

498. The continuing decentralisation of administrative authority to the district level offers special opportunities in terms of financial mobilisation and ensuring that the project responds to felt needs at the district level.

GOVERNMENT CONTRIBUTION

499. The approximate value of direct Government contributions to the project is US$ 2.2 million.

PROJECT INPUTS

500. UNICEF will support the cost of the following project inputs, to the extent available financing permits:

Inputs	1991	1992	1993	1994	1995	Total
Advocacy and Mobilisation of Allies						
Vehicles, four-wheel drive	2	1	1	1	1	6
Motor cycles	10	15	10	10	10	55
Bicycles	100	100	200	150	100	650
Typewriters	5	5	0	0	0	10
Duplicating machine	3	3	3	0	0	9
Public address system	0	0	2	0	0	2
Overhead projecter	0	5	5	0	0	10
TV and video	5	5	0	5	5	20
Megaphones	20	40	60	50	0	170
Mobile public address system	20	20	20	20	20	100
Planning & theme orientation sessions:						0
- national level/11 persons for 3 days	1	1	1	1	1	5
- regional level/11 persons for 3 days	10	10	10	10	10	50
Annual review and strategy formulation:						
- national: 35 for 3 days	1	1	1	1	1	5
- regional: 25 for 3 days	10	10	10	10	10	50
- district: 15 for 2 days	110	110	110	110	110	550
Orientation sessions for:						
- religious leaders	110	110	110	110	110	550
- revolutionary organs	110	110	110	110	110	550
- field staff of sector agencies	110	110	110	110	110	550
Publications:						
- Quarterly CSD newsletter (10,000)	4	4	4	4	4	20
- Handbook on CSD (10,000)	0	1	1	0	0	2
- Convention (local languages 10,000)	0	1	1	0	0	2
- Women's issues (5000/yr)	1	1	1	1	1	5
IE&C materials on AIDS/HIV .. various						various

PROJECT BUDGET

(THOUSANDS OF US DOLLARS)

PROJECT/Activities	1991	1992	1993	1994	1995	TOTAL
1. Advocacy and Mobilisation of Allies						
Institutional support	87	96	90	84	76	433
Involvement of allies	15	15	15	15	15	75
Publications	28	48	48	28	28	180
IE & C on AIDS/HIV	35	40	45	45	50	215
PROJECT TOTAL	165	199	198	172	169	903
Funding.						
General Resources	165	199	198	172	169	903
Funded Sup Funding	0	0	0	0	0	0
Unfunded Sup Funding	0	0	0	0	0	0
PROJECT TOTAL	165	199	198	172	169	903

PROJECT: MASS MEDIA DEVELOPMENT

PROGRAMME SECTOR: SOCIAL MOBILISATION

IMPLEMENTING AND CO-OPERATING AGENCIES:

PRINCIPAL COUNTERPART:	**MINISTRY OF INFORMATION**
PRINCIPAL DONOR:	**UNICEF**
CO-OPERATING AGENCIES:	**MOH, MM&SW**

PROJECT BUDGET: **US$ 261,000**

OVERVIEW

501. Coverage of children- and women-related issues in the Ghanaian press continues to be low due to inadequate equipment, facilities and materials in both the electronic and print media, coupled with the absence of a sufficient number of journalists conversant with CSD and women's issues.

502. To overcome this constraint, the project will strengthen the capacity of the press to research for information and ensure proper documentation and presentation. At the same time, the project will develop interest in reporting on women and children, in addition to increasing reportage on related social development issues, especially health education.

PROJECT COVERAGE/TARGETS

503. The project seeks to reach the audience of the Ghana Broadcasting Corporation (GBC) and the combined readership of the People's Daily Graphic and The Ghanaian Times with continuous information on issues related to women and children.

PROJECT APPROACH

504. The project will seek to enhance coverage of children's issues through three principal channels. In order to improve the number of stories on the concerns of children and women, equipment will be provided to the Ghana Broadcasting Corporation to allow more coverage by its reporters. Second, the problem of inadequate space in the national newspapers for articles related to children and women will be addressed through support for special supplements. Finally, the skills of all journalists, both print and electronic, will be upgraded through the provision of training and incentives to increase reporting on children's issues.

ACTIVITIES

Strengthening of the Ghana Broadcasting Corporation (GBC)

505. The Ghana Broadcasting Corporation (GBC) will be assisted to establish a CSD Unit within its structure with the capacity to develop, document and transmit CSD stories and initiatives, particularly for rural areas, and to prepare CSD programmes. Aspects of "Facts For Life" and women's issues will provide the basis for the development and production of radio and television drama/comedy series as well as jingles and magazine programmes. On the average, about three such documentaries will be produced each year beginning 1992. Each documentary will be dubbed on 120 video cassettes and distributed to all 120 regional and district CSD committees. Towards this end, the NSMCCSD will organise a yearly orientation of about 50 officials from the Ghana Broadcasting Corporation. UNICEF inputs will include support for audio and video production materials and post-production equipment.

Print Media

506. Both the People's Daily Graphic and the Ghanaian Times will produce monthly supplements focusing on events affecting women and children, based on stories submitted by members of the International Club of Journalists on the Rights of the Child (ICJRC). The supplements will stress innovative, low-cost and replicable solutions to common problems experienced by children and women. UNICEF will cover the cost of the newsprint for the four page supplements. All other costs relating to reporting and printing will be borne by the newspapers.

Improving Reporting on CSD

507. This aims at increasing the number of journalists involved in the reporting of CSD and women's issues as well as maintain their interest in the welfare of children and women.

a. The Ghana Institute of Journalism will be assisted to introduce "health reporting" in the curriculum of its students. The course will be designed to increase the knowledge of student journalists on issues related to health and CSD and will assist them in identifying story lines which will be of interest to a general readership. UNICEF assistance will focus on the initial design of the course and provision of instructional materials.

b. The secretariat of the International Club of Journalists for the Rights of the Child (ICJRC) will also be assisted to establish regional branches throughout the country to work closely with regional SMCCSDs. These local clubs will generate regular articles that can be featured on radio, television and regional newspapers. In collaboration with the

Ghana National Commission on Children, the ICJRC will organise an annual seminar for 80 journalists, on special themes as the implementation of the Convention on the Rights of the Child. UNICEF will provide support (supplies and equipment) to the headquarters of the ICJRC in order to improve its capacity to reach and service journalists with relevant information.

c. In order to stimulate and inspire journalists, broadcasters and other communicators to focus more attention on the health needs of children, ICJRC, in collaboration with the Ghana National Commission on Children, will institute opportune schemes such as annual awards for best CSD television documentary, radio broadcast; published article and musical composition to complement such major child-related events as the launching of each year's State of World's Children's Report.

MONITORING

508. Frequency of coverage by radio and television on CSD and women-related issues will be monitored periodically by the NSMCCSD and reports submitted to UNICEF. Trends will be discussed at annual review meetings and will form the basis for any adjustments. Major adjustments will be made during the Mid-Term Review if necessary.

MANAGEMENT OF THE PROJECT

509. The programme will be administered by the NSMCCSD in accordance with a memorandum of understanding which will be drawn up between the GBC, MM&SW, MOH and UNICEF.

LINKAGES/CONVERGENCE

510. This project will ensure the use of the mass media to support the activities of other UNICEF-assisted programmes and projects.

GOVERNMENT CONTRIBUTION

511. Government contributions to the project are expected to equal approximately US$ 1.2 million during 1991-1995.

PROJECT INPUTS

512. UNICEF will support the cost of the following project inputs, to the extent available financing permits:

Inputs	1991	1992	1993	1994	1995	Total
Mass Media Development						
Umatic radio camera and accessories	1		1			2
Vehicle	1					1
Editing bench		1				1
Kits of blank camera and VHS video tapes	2	2	2	2	2	10
Reel-to-reel tape recorders	1	1				2
Professional cassette recorders	30	0	0	0	0	30
Cassette duplicator	1	4				5
Blank tape cassettes	1000	1000	1000	1000	1000	5000
Tape recorders	10					10
Type writers (manual)	10					10
Seminars	1	1	1	1	1	5
Annual awards	5	5	5	5	5	25

PROJECT BUDGET

(THOUSANDS OF US DOLLARS)

PROJECT/Activities	1991	1992	1993	1994	1995	TOTAL
2. Mass Media Development						
Strengthening of GBC	31	86	20	3	3	143
Print media	12	5	12	5	12	46
Improved reporting on CSD	32	10	10	10	10	72
PROJECT TOTAL	75	101	42	18	25	261
Funding.						
General Resources	75	101	42	18	25	261
Funded Sup Funding	0	0	0	0	0	0
Unfunded Sup Funding	0	0	0	0	0	0
PROJECT TOTAL	75	101	42	18	25	261

PLANNING, MONITORING AND EVALUATION PROGRAMME

SUMMARY

513. Improved capacity for social sector development planning, co-ordination and monitoring is a key goal of the 1991-1995 Programme of Co-operation. The Planning, Monitoring and Evaluation (PME) Programme will seek to further this goal by strengthening the collection and analysis of data, especially relating to the situation of children and women, using the data collected as the basis for strengthened planning capacity at the community, district, and regional levels. Special emphasis will be placed on supporting the continuing evolution of the Government's decentralised administrative structure, especially at the district and sub-district levels. The Programme will provide assistance to orient key staff and will also provide essential data processing services and support in the areas of planning and evaluation. The focus of the programme will be on the development of strong, multi-sectoral co-ordination at the district, area (sub-district) and community levels in ten selected districts, and at the regional level in all ten regions of the country. The PME Programme is central to the implementation of all other UNICEF-assisted programmes at the district and regional level, and it will also provide the data upon which all national advocacy efforts will be based.

BACKGROUND

Government Policies and Structure

514. In recent years, the Ministry of Finance and Economic Planning has been the central co-ordinator of most development planning activities in Ghana. The MFEP has three major functional divisions (Investments and Project Analysis - Public Investment Programme; Policy Analysis; and Planning), and also houses the Ghana Statistical Service which is responsible for carrying out and analyzing the National Census, most recently conducted in 1984. The Service also carries out periodic special purpose surveys such as the Ghana Living Standards Survey and the Ghana Demographic and Health Survey (1989). These surveys gather, analyze and publish information on a wide variety of social indicators for use by policy makers, planners and scholars.

515. During the past decade, a number of problems and constraints, mostly related to economic decline and crisis, have impeded effective development planning in Ghana: crisis management has often been required, at the expense of comprehensive planning; information collection has been irregular; planning has been centralised in MFEP with little participation by sector ministries; training and retention of qualified staff have been problematic; and essential logistical support such as equipment, supplies and vehicles have been unavailable.

516. With the initiation of the policy of governmental decentralisation in 1987, certain planning functions were de facto shifted to the regional administrations throughout

the country, although the MFEP remained the central source for statistics. Regional Planning Officers were appointed together with Regional Consultative Committees (later known as Regional Co-ordinating Councils) to oversee development planning in each region. The MFEP assumed the role of co-ordinating the Regional Planning Officers and maintained overall co-ordination of external development assistance.

517. In 1988-1989, the process of decentralisation took another step forward with the publication of PNDC Law 207. This law established District Assemblies as basic units of local government, in all 110 districts of the country. Each District Assembly was, in turn, requested to set up a Social Sector Sub-Committee to co-ordinate social development planning and implementation in each district. At the same time, posts for District Planning Officers were established and, because of their close relationship to the new District Assemblies, these officers were made responsible to the District Administration of the Ministry of Local Government rather than to the Ministry of Finance and Local Government.

518. In 1988, the Government of Ghana launched a major initiative known as the Programme of Actions to Mitigate the Social Costs of Adjustment (PAMSCAD). The purpose of the programme was to plan limited interventions to reduce the negative effects of structural adjustment and the preceding decade of decline on the most vulnerable groups in Ghanaian society. District planning was seen as an essential element of PAMSCAD and, as not all the District Planning Officer posts could be created or filled as originally hoped, Mobile District Planning Teams were created and have had varying success in filling the gap.

519. In early 1990, a new institution, the National Development Planning Commission (NDPC) was set up for the purpose of elaborating national development strategies and consolidating and co-ordinating the various planning units and posts which had been established in recent years. The NDPC is in the process of appointing Economic Planning Officers in each district and, as of mid-1990, is still in the process of getting organised. For this reason, development planning still remains, for all practical purposes, within the jurisdiction of the MFEP at the national and regional levels, while the MLG continues to co-ordinate the work of the District Planning Officers.

520. The 1988 PNDC Law 207 was further refined in mid-1990 when the Government announced the creation of Unit Committees, each representing groupings of 500-1,000 people living in small villages and hamlets. With this final element in place, the decentralisation of local administration foreseen in PNDC Law 207 is now fully implemented, although some posts at some levels remain to be filled. At the community level, groups of 500 people elect the Unit Committees, each made up of a mixture of elected officials and tribal elders. Groups of Unit Committees form Electoral Areas, each of which elects one Assemblyman or Assemblywoman to participate in the District Assembly. Groups of two to three Electoral Areas form one Town Council or Area Council (depending on whether they are urban or rural) which is comprised of Assemblymen/Assemblywomen,

together with representatives of national ministries with representation at this "sub-district" level. It is expected that Area Officers will be appointed in the near future to extend governmental administration to Area level. (Note that each Town Council/Area Council corresponds roughly to the Level B, or health centre/post level, of the Ministry of Health structure.)

521. Two thirds of the Assemblymen/Assemblywomen are elected by their constituents while one third are appointed by the District Secretary. The District Secretary is appointed by the Ministry of Local Government and serves as the executive counterpart to the legislative Assembly. (Note that District Administration corresponds to the Level C of the Ministry of Health structure)

522. Each District Secretary, in turn, reports to a Regional Secretary (a cabinet rank minister) in each region who is supported by the regional staff of the various sector ministries. (See paragraph 111 for more information on the decentralised structure of Government.)

Problems Addressed by the Programme

523. During the past several years, the Government of Ghana has made a number of efforts to improve its development planning capacity. The current restructuring of planning responsibilities and the creation of the NDPC clearly demonstrate the high priority given to the crucial area by the Government. Nonetheless, some difficulties have resulted from the severe financial constraints faced by the Government, together with the changing roles and responsibilities in the field of planning.

524. Government statistics, while including children as a group, do not highlight the plight of children as an entity deserving special attention. In addition, information resulting from studies and surveys carried out by the Government does not cover some basic areas of critical importance in determining the welfare of children (e.g., maternal mortality rates). Neither are these data compiled and presented in such a way as to provide district level planners with the precise information they may require to plan development activities to benefit children and women. The last national census was conducted in 1984, and most currently accepted data are only projections from this base. For example, much information concerning prevalence of disease and coverage of services is based on extrapolations of relatively limited samples or areas within the country.

525. In the area of planning, there is a clear need for a multi-sectoral approach at both the district and regional level in order to actually achieve integration within the new decentralised system. The roles of the District Assemblies and their Social Sector Committees, the Community Development Department of the MLG, the district offices of the sector ministries (e.g., Health, Education, Agriculture, etc.), and the various planning units remain to be clarified and would benefit from greater co-ordination. This is particularly true at the regional, district and area levels where co-

ordination with national sectoral ministries is especially complex. In addition, the process of preparing the 1989-1990 Situation Analysis and the 1991-1995 Programme of Co-operation has clearly shown the need for improved statistical information for planning, monitoring and evaluating all programme activities.

PAST CO-OPERATION

526. Previously, UNICEF played a limited role in the area of planning at the regional and district levels. With the refocusing of the Programme of Co-operation in 1987, however, UNICEF Focal Persons were named in each Regional Administration for the purpose of co-ordinating UNICEF assistance and providing some capacity for planning UNICEF inputs vis a vis those of the Government. The Government and UNICEF undertook a joint review of their co-operation in May 1988 at the time of the Mid-Term Review. This meeting was critical in re-orienting the course of UNICEF assistance in Ghana and was to have been followed up with quarterly and annual review meetings. These were not carried out as planned, which was one of the factors leading to the dispersion of resources noted under the section on "Lessons Learned" (see chapter entitled "Analysis of Past Co-operation").

527. In the area of data collection, UNICEF activities have been limited to a relatively small number of specific studies and to preparations for the 1991-1995 Programme of Co-operation in which a major Situation Analysis was carried out with input from the Ghana Statistical Service, the three universities and several consultants. The 1989-1990 Situation Analysis pointed out many critical areas of concern related to children and women in Ghana (see chapter entitled "Summary of the 1989-1990 Situation Analysis"). This document, completed in August 1990, serves as a partial baseline against which the impact of UNICEF assistance will be measured in the future. Special studies were limited to a national nutrition survey in 1986, a study of knowledge, attitudes and practices (KAP) regarding vaccinations, undertaken in 1988, and a vaccination coverage assessment in February 1989.

528. UNICEF has developed and maintained a variety of programme monitoring tools and data processing capabilities. Foremost among these are the Global Field Support System (GFSS) and the Programme Information Data Base (PIDB) which provide up-to-date information on the status of UNICEF inputs.

529. Experience with the establishment of the UNICEF "Focal Persons" at the regional level has shown that improved co-ordination is both feasible and productive. The "Focal Persons" have assisted in co-ordinating efforts with the various levels of Government and with other donors and have reduced time-consuming and duplicative communications with various branches within each Regional Administration. Notwithstanding these positive aspects, experience has also shown that co-ordination could be further improved. The "Focal Persons" are generally limited to co-ordinating UNICEF assistance and are not necessarily centrally involved in overall planning for their region.

530. The process of preparing the 1989-1990 Situation Analysis has also shown that there is room for improvement. The Situation Analysis was prepared exclusively using secondary resources, many from different years and using varying standards and definitions. While the Ghana Statistical Service has a tremendous volume of data, not all of it is available in comparable formats, thus hindering analysis. In addition, some gaps in Government data, such as in the area of maternal mortality, led to the use of incomplete or outdated information.

Linkages with New Programme

531. The proposed PME Programme is firmly based on the lessons learned during the past Programme of Co-operation. The need for improved district- and regional-level co-ordination of UNICEF inputs has led directly to the formulation of the proposed programme. In addition, the need for continuous monitoring of the status of children and women is the basis for new initiatives in the area of research and analysis. Continuing efforts will be made in the area of joint programme planning and monitoring with the Government, and UNICEF will seek to share its improved data processing capacity with district and regional administrations/institutions to promote more effective planning. Finally, the process of programme and project evaluation undertaken during the last Programme of Co-operation will be continued and expanded to provide a basis for on-going analysis of programme effectiveness.

PROPOSED PROGRAMME

532. the establishment of a new programme in the area of Planning, Monitoring and Evaluation constitutes a major innovation of the 1991-1995 Programme of Co-operation. In order to help address the problem of dispersion of UNICEF resources and, thus, the limited impact of interventions, the 1991-1995 Programme of Co-operation will seek to focus national programmes in the areas of Health and Nutrition, Water and Sanitation, and Basic Education on one district in each of the ten regions, where the effectiveness of co-ordinated interventions can be demonstrated. A key element in this approach will, therefore, consist of building the necessary capacity for planning, implementing and monitoring activities and inputs at the community, district, regional and national levels. Emphasis will be given to the strengthening of the multi-sectoral institutions of the Ministry of Local Government at all levels. These will not only co-ordinate the inputs of UNICEF and other donors in the light of data on the situation of children and women but also provide continual monitoring of programme performance.

Programme Objectives

533. The general objective of the PME Programme will be to:

a. Enhance the capacity of Government staff at all levels to effectively monitor the status of children and women;

b. Build national capacity to identify and prioritise social development needs based on the data generated by monitoring systems and utilising processes that effectively relate community needs to national priorities;

c. Strengthen capacity to effectively plan, implement and evaluate social development programmes.

Coverage/Target Population

534. The programme will seek to improve the quality and coverage of basic social services to approximately one million inhabitants in ten selected districts in the country. The Programme will be targeted primarily to planners at the community, sub-district (area) and district levels and, to a lesser extent, to regional level planners who will provide support to district officials. National planners and managers will indirectly benefit from the data and evaluations generated by the Programme. Regional efforts will cover all the ten regions in the country, while efforts at the district level will focus on the ten districts selected in consultation with Regional Administrations to serve as demonstration sites for integrated and convergent approaches which will subsequently be replicated elsewhere. Within those districts, the Project will focus on 1,186 Unit Committees for community-level involvement, while all 15,924 Unit Committees in the ten districts will benefit from improved co-ordination and planning at the district and sub-district levels (see paragraph 111 for more information on the structure of Unit Committees in the ten selected districts).

Programme Strategy

535. The PME Programme will be implemented in accordance with the following general strategies:

a. Enhancement of the capacity of Government staff at all levels and of communities themselves to assess and monitor the situation of children and women;

b. Enhancement of the capacity of regional, district and sub-district staff to effectively plan development activities in accordance with expressed needs and in full consultation and involvement with community leaders, especially those who are women;

c. Focus on the ten districts selected for special attention by other UNICEF-assisted programmes in order to demonstrate the synergistic results that can be achieved through effective micro-planning and programming in consultation with communities;

d. Development of replicable models for planning and programme management.

Complementarity and Linkages

536. The PME Programme is integrally related to the other programmes in the 1991-1995 Programme of Co-operation, as it will establish the framework on the basis of which these other programmes will achieve their results at the regional and district levels. Multi-sectoral committees to be established and trained through the PME Programme will play a central role in planning, implementing and monitoring all UNICEF assistance below the national level. In addition, data collected and analyzed as part of the PME Programme will be essential in planning and monitoring activities within all other UNICEF-assisted programmes and projects. Finally, the planning, data processing and evaluation capabilities to be developed or enhanced through the programme will lay a firm foundation for planning the 1996-2000 Programme of Co-operation.

Constraints/Opportunities

537. The most obvious constraint to effective implementation of the PME Programme is the current transitional state of the Government planning apparatus and the continuing evolution of the local administrative structure. Once responsibilities for planning are clearly spelled out and consolidated within the various Government institutions, the effectiveness of the programme will be increased. Nonetheless, the transition itself also represents an opportunity for UNICEF to provide support to the process of consolidation to help ensure that the special needs of children and women are adequately addressed.

538. As with all development activities in Ghana, the implementation of the PME Programme may also be affected by overall budgetary constraints related to deteriorating economic conditions. Here again, however, the PME Programme is expected to analyze the potential impacts and social costs of such developments and, therefore, provide an opportunity to assess options and plan the efficient and equitable allocation of scarce resources.

PROGRAMME BUDGET/TIMEFRAME

(THOUSANDS OF US DOLLARS)

PROJECT/Activities	1991	1992	1993	1994	1995	TOTAL
PLANNING, MONITORING AND PROGRAMME						
1. Research and Analysis	158	24	70	175	40	467
2. Programme Monitoring	65	20	20	20	20	145
3. Evaluation	0	15	35	15	15	80
SUBTOTAL	223	59	125	210	75	692
Programme Support	34	32	32	32	32	162
TOTAL PROGRAMME	257	91	157	242	107	854
Funding.						
General Resources	257	91	157	242	107	854
Funded Sup Funding	0	0	0	0	0	0
Unfunded Sup Funding	0	0	0	0	0	0
TOTAL PROGRAMME	257	91	157	242	107	854

PROJECT: RESEARCH AND ANALYSIS

PROGRAMME SECTOR: Planning, Monitoring and Evaluation

IMPLEMENTING AND CO-OPERATING ORGANISATIONS:

MINISTRIES:	**MFEP/GHANA STATISTICAL SERVICE**
PRINCIPAL DONOR:	**UNICEF**
OTHER AGENCIES:	**MLG, MOH, MOA, MM&SW, NDPC**

PROJECT BUDGET: **US$ 467,000**

OVERVIEW

539. Essential demographic and service coverage information is scarce, insufficiently desegregated and, at times, contradictory, particularly regarding specific data related to the welfare of children and women. The last national census was conducted in 1984 and another is not planned until 1994. Publication of the data from the last census is expected in late 1990, however it will be desegregated by the 65 administrative districts which existed in 1984 rather than by the 110 districts which currently exist. Data from other studies such as the Ghana Living Standards Survey and the Ghana Demographic and Health Survey is desegregated in the same manner and, in addition, does not include some essential information such as maternal mortality, nutritional status of children or information on knowledge, attitudes and practices related to health.

540. This lack of reliable information hinders effective development planning, especially at the district level where the District Administrations of the 110 districts, together with the District Assemblies, must plan development efforts based on the actual needs of the population in their district. The lack of adequate and continuously updated information also makes it extremely difficult to accurately monitor the coverage and impact of development initiatives. In addition, in some instances where reliable data has been gathered in national or small-scale investigations, the information is scattered, difficult to locate and analyze, and frequently uses varying standards and denominators. The Research and Analysis Project will seek to improve this situation by assisting the Ghana Statistical Service, as well as Regional and District Administrations, in identifying, prioritising and collecting key information not found in existing data bases. This information will then be analyzed both to assess the impact of overall economic and social trends (e.g., Structural Adjustment) as well as of UNICEF-assisted development efforts on vulnerable groups.

PROJECT COVERAGE/TARGETS

541. The Research & Analysis Project will provide information to planners at the national and regional levels and in ten selected districts. These personnel will be provided with the data collected and assisted to make maximum use of it in prioritising development needs and planning activities within their jurisdiction. In addition, a total of almost 1,200 communities in ten selected districts will benefit from carrying out community surveys based on participatory research methodology.

542. Indirectly, all children and women in Ghana will benefit from improvements in the planning, design and implementation of development efforts made possible by the data to be provided through this project.

ACTIVITIES

National Study of Mortality and Morbidity

543. In order to complement existing national sources such as the 1984 Census, the biennial Ghana Living Standards Survey and the Ghana Demographic and Health Survey, two major studies will be commissioned during 1991-1995 in collaboration with the Ghana Statistical Services. The first study will provide information on a select group of indicators including the rates of infant, under five and maternal mortality and morbidity and their causes. The information will be collected and desegregated by district for use in planning district-level development initiatives. The study will be launched in 1991 and completed by mid-1992. The study will be repeated in 1994 as part of the next Situation Analysis, thus providing updated information for programme planning as well as a measure of changes in key indicators over the 1991-1994 period. It is expected that both studies will use a cluster sampling method. UNICEF will provide technical and financial support for instrument design and testing, for training of survey supervisors and enumerators, and for travel and subsistence costs associated with the surveys.

National Nutrition Survey

544. The second major study, to be undertaken in 1993 in collaboration with the MOH, MOA and MFEP, will be a National Nutrition Survey which will follow-up on a similar survey undertaken with UNICEF assistance in 1986. The Nutrition Survey will make use of both national sampling and more specific data obtained from the ten districts in which the District Primary Health Care project will be operating. The results of the survey will constitute an important input into the preparations for the 1996-2000 Programme of Co-operation and, in conjunction with other national studies, will also provide a basis for monitoring the continuing impact of structural adjustment policies and PAMSCAD on the welfare of children and women.

Special Studies

545. In the two major studies noted above, a number of special studies will also be commissioned to shed light on problems which may be worsening but on which information is currently limited or non-existent. These problems include teenage pregnancy in rural and urban areas, urban problems such as street children and working children, and other problems identified during the course of the 1991-1995 Programme of Co-operation. It is expected that at least one such study each year will be undertaken in collaboration with researchers from the three universities, Governmental agencies, bi-lateral and multilateral donors and NGOs. UNICEF will provide technical assistance in the form of consultants and staff expertise and will also provide transport, office supplies and equipment, and subsistence as required.

KAP Studies

546. In order to provide the information necessary to design programmes and interventions which are acceptable to the population, two KAP studies will be undertaken during the 1991-1995 Programme of Co-operation. The first KAP study, to be undertaken in early 1991, will focus on knowledge, attitudes and practices related to family and community health. The study will seek to gather information as to specific traditional practices and taboos which may have negative impacts on children's health and will seek to identify means by which these practices and beliefs can be altered or influenced to the benefit of the child.

547. The second KAP study, planned for 1993, will focus more specifically on attitudes and practices relating to health and social services which are already available. The principal areas of inquiry will relate to health, water and sanitation services and will seek to identify reasons for dropouts from immunisation programmes, for non-use of sanitary facilities, non-attendance at school, etc.

548. Both KAP studies will focus heavily on the ten districts in which UNICEF-assisted programmes converge, however both will also sample other districts as well as a control group. Information will be analyzed in collaboration with the MOH, MOE, MOA and MLG and will be desegregated by district and provided to Government officials involved in planning social services. UNICEF inputs to these studies will include technical assistance, office equipment and supplies and travel and subsistence for researchers.

District Surveys

549. Because of the need for more in-depth data on the situation and trends in the ten districts on which UNICEF assistance will focus, surveys will be conducted in each of these districts twice during the Programme of Co-operation (1991 and 1994). These surveys will take as their starting point the data collected and published by the Ghana Statistical Service in 1990. It is expected that the surveys will provide more detailed information specifically on women and children and this

will be used to provide a longitudinal portrait of socio-economic trends at the district level. Although the districts do not constitute a representative sample of the country, the findings of the district surveys will also be useful to validate the data gathered from the national studies and to monitor trends directly related to areas of UNICEF assistance. A primary objective of the district surveys is to assist district level planners to better target development assistance and, for this reason, the surveys will be tailored to the interests and needs of each district while at the same time collecting data for comparison nationally. The surveys will be undertaken in collaboration with the District Administrations, and the District Planning Officers, with support from the Regional Planning Officers. The information from all district studies will be aggregated by region as a major input into the Analysis of the Situation of Women and Children, to be carried out in 1994 as part of the process of preparing the 1996-2000 Programme of Co-operation.

Technical Support for Community Surveys/Participatory Research

550. In order to directly involve communities in assessing their own needs, resources and solutions to development problems and thus supporting the activities of all other UNICEF-assisted programmes, support will be provided for participatory research to be undertaken as part of the District PHC Development project. undertaken at the community level in the ten selected districts. Community Development Officers and staff from the Non-Formal Education Division working at the sub-district level will organise and supervise this research in all communities targeted for assistance each year. It is expected that existing women's groups or new groups formed through UNICEF-assisted interventions will actually carry out the community surveys in collaboration with local leadership.

551. While the content of these community needs assessments will be completely designed by the communities themselves, it is hoped that they will also provide some data which, in conjunction with the national and district studies, can be used to track trends at the community level. Participatory research/surveys will be phased in together with the District PHC Development project, and will be used to develop relevant methodologies and materials, to test and validate approaches, and to train trainers at the district level to permit further expansion of the activities in subsequent years.

552. In mid-1993, two staff from the national planning institutions (MFEP and NDPC) will be oriented in the Sentinel Sites methodology developed by the Institute of Tropical Research in Mexico. Following their return, a limited number of communities which have successfully conducted community surveys, probably between five and ten per district, will be selected to carry out annual surveys in order to provide longitudinal information on trends at the community level. These Sentinel Sites will be used in evaluating the impact of UNICEF assistance during the reviews at the national level (through the Evaluation Project).

Publication of Data

553. Data collected through the national studies, the district surveys and the community surveys will be computerised, analyzed and presented in an annual publication tentatively entitled "The State of Ghana's Children". Publication will be timed to coincide with the annual release of UNICEF's "State of the World's Children". While the focus of the publication will be on presentation and analysis of statistical information for use by planners, it is also expected to become a central tool for UNICEF advocacy with policy makers, the media, and opinion leaders. UNICEF will support the costs of an editorial team to analyze and present the data, and will provide financial support for the publication of at least 1,500 copies for distribution.

Programme Preparation

554. Beginning in 1994, planners and key staff from sectoral ministries will be involved in the preparation of an updated Analysis of the Situation of Children and Women in Ghana, based on the results of the national and district studies. The study will highlight trends at the regional level during the period 1990-1994 and will serve as the basis for the preparation of a Strategy Paper, a Strategy Meeting, a Master Plan of Operations for the period 1996-2000 and a Preview Meeting to review all these documents. UNICEF inputs to this activity will consist of technical assistance, secretarial support, honoraria, travel and subsistence, location rental, and production and duplication of documents.

TIMEFRAME FOR PROJECT ACTIVITIES

	1991	1992	1993	1994	1995
National Morality/Morbidity Studies	xxxxxxxx			xxxxxxxx	
National Nutrition Survey			xxxxxxxx		
KAP Studies	xxxxxxxx	xxxxxxxx			
Special Studies	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxx
District Surveys	xxxxxxxx			xxxxxxxx	
Community Surveys	xxxxxxxx	xxxxxxxx	xxxxxxxx		
Programme Preparation				xxxxxxxx	xxxxxxx

LINKAGES/CONVERGENCE

555. The Research & Analysis Project will provide data for planning and evaluating all other programmes within the 1991-1995 Programme of Co-operation. As noted above, the project will have a special link with Nutrition Surveillance activities to be undertaken as part of the District PHC Development Project for the purpose of

monitoring the social impact of adjustment policies. In addition, the reports and studies to be published as part of the project will constitute essential inputs into advocacy efforts within the Mobilisation Programme. The Community Survey activity will be directly linked with all planning activities and with all other UNICEF-assisted interventions targeted on communities in the ten selected districts. All data gathered during the first four years of programme implementation will feed directly into the preparation of the 1996-2000 Programme of Co-operation.

MONITORING

556. The project will be monitored at the national level by UNICEF staff who will also make quarterly field visits to each region and each of the ten selected districts to meet with planners. In addition, UNICEF staff, together with district planners, will make periodic visits to communities involved in participatory research activities to assess progress and problems. These visits will result in reports being submitted to the Annual Planning and Review Meetings which will assess overall project performance.

PROJECT INPUTS

557. UNICEF will support the cost of the following project inputs, to the extent available financing permits:

Inputs	1991	1992	1993	1994	1995	Total
PLANNING, MONITORING AND EVALUATION						
Research and Analysis						
National mortality/morbidity study	1			1		2
National nutrition survey			1			1
yearly specialised studies	1	1	1	1	1	5
KAP studies	1	1	0			2
District surveys (10 PHC)	1			1		2
Technical support for com. surveys						0
Publications	1	1	1	1	1	5
Programme preparations	0	0	0	1	1	2

PROJECT BUDGET

(THOUSANDS OF US DOLLARS)

PROJECT/Activities	1991	1992	1993	1994	1995	TOTAL
PLANNING, MONITORING AND PROGRAMME						
1. Research and Analysis						
National IMR/MMR study	84	0	0	85	0	169
Nat'l nutrition survey	0	0	20	0	0	20
District surveys	50	0	0	50	0	100
KAP studies	4	4	0	0	0	8
Tech. support Com. parti.resear	10	10	40	10	10	80
Publication of data	10	10	10	10	10	50
Programme preparation	0	0	0	20	20	40
PROJECT TOTAL	158	24	70	175	40	467
Funding.						
General Resources	158	24	70	175	40	467
Funded Sup Funding	0	0	0	0	0	0
Unfunded Sup Funding	0	0	0	0	0	0
PROJECT TOTAL	158	24	70	175	40	467

PROJECT: PROGRAMME MONITORING

PROGRAMME SECTOR: PLANNING, MONITORING AND EVALUATION

IMPLEMENTING AND CO-OPERATING ORGANISATIONS:

MINISTRIES:	**MFEP, MLG**
PRINCIPAL DONOR:	**UNICEF**

PROJECT BUDGET: **US$ 145,000**

OVERVIEW

558. In order to fully implement the PME Programme and adequately monitor UNICEF assistance, support will be provided to strengthen, develop and operate systems to collect and process information related to programme implementation. Particular emphasis will be given to the development of easy-to-use software packages for planning and monitoring inputs. Once developed, the use of these systems at all levels will facilitate the aggregation of data to provide a national overview as well as regional and district breakdowns of relevant data. Micro and laptop computers, printers and other peripherals will be made available to selected managers at each level and, where such equipment is not deemed necessary or appropriate, typewriters and/or forms will be provided to ensure that the data collected is compatible with the computer software systems in use at different levels.

PROJECT COVERAGE/TARGETS

559. Planners and managers will be the principal direct beneficiaries of the project. As with other projects in the PME Programme, all children and women in Ghana, and especially in the ten selected districts, will benefit from improvements in social development projects made possible by enhanced planning capacity.

ACTIVITIES

Software Development

560. During the initial orientation session with national level planners in early 1991, efforts will be made to identify software needs related to programme monitoring. These needs will then be validated and refined together with planners at the regional, district and community levels, following which a consultant will be engaged to design a simple reporting format which can be used manually at the community level and which can be aggregated and computerised at the district, regional and national levels. Training in the use of the software package will be given by the consultant at the regional and district levels. At the community level, Community

Development Staff and the extension workers of the sectoral ministries will provide the necessary orientation to the reporting format. UNICEF inputs will include technical assistance, one consultancy, software documentation, and reproduction of report forms.

Computerisation of Monitoring and Reporting

561. Following the development of the necessary software, a limited number of micro-computers, printers and peripherals will be made available to Regional Planning Officers and computer-compatible forms and typewriters will be provided to District Planning Officers for use in monitoring programme inputs and consolidating data gathered in the district level surveys to be carried out each year (see Research & Analysis Project). Training in the use of the equipment will be carried out by the same consultant who will develop the software, and delivery of the equipment will take place simultaneously with the training course in each location. UNICEF inputs will consist of technical assistance, ten micro-computers (one in each region) each equipped with one printer and necessary supplies, and typewriters for each district.

Annual Planning and Review Meetings

562. In order to ensure proper monitoring of UNICEF assistance and the preparation of annual Plans of Action, Annual Planning and Review Meetings will be held with national, regional and district counterparts in November of each year. The meetings will normally take place in Accra and will review reports prepared by each district and region together with any research studies and programme or project evaluations which have been completed during the year. UNICEF inputs to these meetings will include technical assistance, preparation and duplication of documents, secretarial support, location rental, honoraria, travel and subsistence.

LINKAGES/CONVERGENCE

563. The Programme Monitoring Project will provide the basis on which all other UNICEF-assisted programmes and projects will be monitored during the course of the Programme of Co-operation. Within the PME Programme, the equipment and software to be provided through this project will directly serve the Research & Analysis and the Evaluation Projects (see below), and training in the use of equipment and software will be co-ordinated with the activities under the Training Project.

MONITORING

564. The Programme Monitoring Project will be monitored by UNICEF staff on a continual basis. Key indicators will be development and use of the software packages, installation of equipment at the regional and district levels, completion of training at those levels, and timely submission of the required reports. Overall

project performance will be monitored on the basis of the annual Plan of Action at the time of each Annual Planning and Review Meeting.

PROJECT INPUTS

565. UNICEF will support the cost of the following project inputs, to the extent available financing permits:

Inputs	1991	1992	1993	1994	1995	Total
Programme Monitoring						
Four-wheel drive vehicle	1					1
Software packages and refinements	1	1	1	1	1	5
Micro computers per region	10	0	0	0	0	10
Annual planning and review meetings	1	1	1	1	1	5

PROJECT BUDGET

(THOUSANDS OF US DOLLARS)

PROJECT/Activities	1991	1992	1993	1994	1995	TOTAL
2. Programme Monitoring						
Software development	10	5	5	5	5	30
Computerisation of monitoring and reporting	50	10	10	10	10	90
Annual planning/review meetings	5	5	5	5	5	25
PROJECT TOTAL	65	20	20	20	20	145
Funding.						
General Resources	65	20	20	20	20	145
Funded Sup Funding	0	0	0	0	0	0
Unfunded Sup Funding	0	0	0	0	0	0
PROJECT TOTAL	65	20	20	20	20	145

PROJECT: EVALUATION

PROGRAMME SECTOR: PLANNING, MONITORING AND EVALUATION

IMPLEMENTING AND CO-OPERATING ORGANISATIONS:

MINISTRIES:	**MFEP, NDPC, MLG, SECTOR MINISTRIES**
PRINCIPAL DONOR:	**UNICEF**
OTHER AGENCIES:	**DONORS SUPPORTING SUPPLEMENTARY FUNDED PROGRAMMES**
PROJECT BUDGET:	**US$ 80,000**

PROBLEM

566. During the 1986-1990 Programme of Co-operation, only a limited number of programme evaluations were planned and carried out, and those that were completed varied considerably in quality and usefulness. The lack of information regarding programme performance and impact greatly hindered the preparation of the 1991-1995 Programme of Co-operation. In addition, the lack of regular annual reviews of Government/UNICEF co-operation and progress on individual projects has impeded the effectiveness of programmes in the past. In order to minimise similar problems in the future and in order to ensure more consistent quality, the Evaluation Project is designed to consolidate all programme evaluations into one area under the responsibility of a single unit in UNICEF's Accra office.

PROJECT COVERAGE/TARGETS

567. The Evaluation Project will produce approximately one programme evaluation each year, or a total of approximately six evaluations during the 1991-1995 Programme of Co-operation. The evaluations will be geared primarily to serve programme planners and implementers and, when required, donors who have provided resources for Supplementary Funded Programmes.

ACTIVITIES

Programme/Project Evaluations

568. In order to ensure that UNICEF-assisted programmes achieve maximum impact on their intended target groups, joint evaluations will be undertaken by Government implementing agencies and UNICEF each year. The Government may designate representatives from MFEP, NDPC, MLG or other agencies to participate together with the sector ministry directly responsible for implementation. UNICEF may call on outside technical expertise from its regional or headquarters offices or from other agencies.

569. The Evaluation Project will seek to evaluate each major UNICEF-assisted programme at least once during the Programme of Co-operation. The results of these evaluations will be fed into the Mid-Term Review planned for June/July 1993 and the preparations for the 1996-2000 Programme of Co-operation. The calendar will be, tentatively, as follows:

a. January 1991: Health and Nutrition (EPI/ORT)
b. May 1992: Social Mobilisation (Facts for Life)
c. October 1992 Health and Nutrition (Nutrition)
d. March 1993: Water and Sanitation (Guinea worm)
e. February 1994: Health and Nutrition Programme (overall)
f. November 1994: Basic Learning Needs Programme (overall)

570. Programmes will be evaluated during two-week missions of teams comprising teams of Government and UNICEF Ghana staff, supported by UNICEF Headquarters or other offices as appropriate. The teams will conduct interviews, review regular UNICEF and Government programme monitoring tools and outputs, and review trend data on the situation of women and children, which will be collected through the Research & Analysis Project and by other Government and donor institutions.

571. UNICEF inputs to this project will consist primarily of technical assistance, secretarial support, computer facilities and duplication of reports; however, limited honoraria, travel and subsistence costs associated with evaluation missions will also be supported. The EPI Evaluation planned for 1991 is funded by the EPI/ORT Project. All other evaluations are funded by the Evaluation Project.

Mid-Term Review

572. A Mid-Term Review (MTR) of the entire Government/UNICEF Programme of Co-operation will take place in June/July 1993. Participants will include senior staff from all sector ministries as well as senior staff from national-level planning institutions. The meeting will review the results of the national survey to be carried out in 1992, the progress of the Programme of Co-operation at each level and the results of programme evaluations to be carried out in preparation for the MTR. The MTR will provide an opportunity to recommend mid-course corrections or re-orientation of programmes in order to maximise their impact and improve their management. UNICEF inputs to this meeting will include technical assistance, production and duplication of studies, evaluations and documents (carried out under the Research & Analysis Project) as well as secretarial support, location rental, honoraria, travel and subsistence.

LINKAGES/CONVERGENCE

573. As the Evaluation Project will be evaluating all other programmes and projects, it will be integrally related to each of these. In addition, the project will be

closely linked to the other projects within the PME Programme as these will provide much of the capacity required to effectively evaluate UNICEF-assisted programmes. The Annual Planning and Review Meetings, the Mid-Term Review and the preparations for the 1996-2000 Programme of Co-operation will all be based, in part, on the evaluations to be carried out as part of this project.

MONITORING

574. The Evaluation Project will be monitored as part of the Annual Planning and Review Meetings and the Mid-Term Review to be held in June/July 1993. The key indicators will be the actual completion of each evaluation as indicated in the annual Plans of Action.

PROJECT INPUTS

575. UNICEF will support the cost of the following project inputs, to the extent available financing permits:

Inputs	1991	1992	1993	1994	1995	Total
Evaluation						
Programme/project evaluations	1	1	1	1	1	5
Mid-term review	0	0	1	0	0	1

PROJECT BUDGET

(THOUSANDS OF US DOLLARS)

PROJECT/Activities	1991	1992	1993	1994	1995	TOTAL
3. Evaluation						
Programme/Project evaluations	0	15	15	15	15	60
Mid-term review	0	0	20	0	0	20
PROJECT TOTAL	0	15	35	15	15	80
Funding.						
General Resources	0	15	35	15	15	80
Funded Sup Funding	0	0	0	0	0	0
Unfunded Sup Funding	0	0	0	0	0	0
PROJECT TOTAL	0	15	35	15	15	80