Ghana's Development Agenda and Population Growth: The Unmet Need for Family Planning

National Population Council
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Abbreviations

AIDS	Acquired immune deficiency syndrome
BCC	Behavioural Change Communication
CBR	Crude Birth Rate
CDR	Crude Death Rate
CPR	Contraceptive Prevalence Rate
ECA	Economic Commission for Africa
EFA	Education for All
ESP	Education Strategic Plan
FCUBE	Free Compulsory Universal Basic Education
FP	Family Planning
GAR	Greater Accra Region
GDHS	Ghana Demographic and Health Survey
GDP	Gross Domestic Product
GHS	Ghana Health Service
GER	Gross Enrolment Rate
GETFund	Ghana Educational Trust Fund
GPRS	Ghana Poverty Reduction Strategy
HIV	Human immunodeficiency virus
IEC	Information Education and Communication
ICPD	International conference on Population and Development
IMF	International Monetary Fund
IMR	Infant Mortality Rate
JSS	Junior Secondary School
MCC	Millennium Challenge Corporation
MDGs	Millennium Development Goals
MOH	Ministry of Health
NEPAD	New Economic Partnership for Africa's Development
NHIS	National Health Insurance Scheme
NPC	National Population Council
PIP	Population Impact Project
PoA	Programme of Action
RAPID	Resource for the Awareness of Population Impacts on Development
RIPS	Regional Institute for Population Studies
SHARP	Strengthening HIV/AIDS Response Partnership
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
USAID	United States Agency for International Development

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Acknowledgements

Foreword

Ghana is currently faced with the challenge of ensuring the realisation of the policy and programme goals contained in the Ghana Poverty Reduction Strategy (GPRS II) as well as the Millennium Development Goals (MDGs). This can only be made possible if the government's capacity for national development efforts keeps pace with the rate of growth of the population, because population is both a determinant of development and also could be influenced by development.

The Government of Ghana is therefore committed to effectively addressing its population needs and ensuring the well-being of its citizenry. Towards this end, the Government adopted the National Population Policy: revised edition in 1994. Since then, the Resource for the Awareness of Population Impacts on Development (RAPID) Model was initiated in collaboration with the Population Impact Project, the National Population Council Secretariat, Ghana Statistical Services and other partners, through funding from the POLICY Project and the earlier projects of USAID. The success of the first series of RAPID used as a tool for advocacy and policy dialogue informed its revision and update in 2000. However, funding constraints limited the full publication of 2000 update.

This new RAPID builds upon the 2000 revision and covers population dynamics, current levels of fertility and mortality in Ghana, the consequences of unmet need for family planning, and the impact of population growth on development especially in the context of Government meeting its own development goals, as well as the internationally agreed MDGs.

Most of the data used in this publication are based on the 2000 Population Census, GDHS and other sources compiled and reviewed at a workshop in September 2005 by a technical team comprising representations from the following: National Population Council Secretariat, Ghana Statistical Service, the Population Impact Project, Regional Institute for Population Studies (RIPS), The School of Public Health - all of the University of Ghana, Legon. Other representatives came from Pathfinder International, the Ghana AIDS Commission, The SHARP Project, Environmental Protection Agency and the Ministry of Food and Agriculture.

Two scenarios were used in formulating the current RAPID Model and the socio-economic implications of each scenario are reflected in this publication. The objective of the model continues to be its use as an advocacy tool in sensitizing stakeholders, including government, opinion leaders, policy and decision makers, of the implications of unmet family planning need, rapid population growth, and its socio-economic consequences. It is therefore recommended to government leaders at all levels, policy makers, programme managers and all other stakeholders involved with population and reproductive health issues.

The National Population Council and its Secretariat, wish to thank the POLICY Project/Futures Group and USAID who provided core-funding for this activity, and other collaborating partners who contributed to the successful completion of this publication. It is my hope that the collaboration and harmonized efforts which have already started would be sustained in order to ensure that our collective efforts are crowned with the successful attainment of our national population and development objectives.

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Accra, Ghana

1.0 Introduction

1.1 Population and Development in Ghana

Ghana has one of the fastest growing populations in the world despite the desire of many Ghanaian women and men for better spaced, smaller families, and this high growth rate has profound implications for development and quality of life in Ghana. The publication titled 'State of Ghana Population Report 2003: Population, Poverty and Development' made a compelling case regarding the need to re-focus the nation's energies on managing its human development efforts - its most important resource. The Minister of Finance and Economic Planning at the time, Hon. Yaw Osafo Marfo, in the foreword to the document notes, that managing the country's population represents an invaluable contribution to the national development planning process and to the Ghana Poverty Reduction Strategy. The document under reference provided a comprehensive review of the interplay between selected strategic development sectors such as education, health, environment, gender on the one hand, and population and poverty on the other.

Addressing population growth is an important matter in Ghana's quest to develop programmes that promote growth and reduce poverty. In view of this compelling case, an analysis was conducted using the Resource for the Awareness of Population Impacts on Development (RAPID) model to help inform the nation's effort at achieving the Millennium Development Goals (MDGs). The analysis focused on "wanted" fertility versus actual fertility, indicators of an unmet demand for family planning, and the high continuing rates of maternal and infant mortality and morbidity to which unintended pregnancies contribute. The analysis also relies on information from the 2000 Population Census and other sources, and projects two population growth scenarios (a high fertility using total fertility rate (TFR) of 3.6 and a low TFR of 3.0 children per woman by 2015) while looking at the sectoral implications for achieving the MDGs in education, job creation, health and agriculture, urbanization and for achieving the family planning goals as contained in the revised population policy. The conclusion in each case is that the growth and poverty reduction strategy goals may not be achieved if efforts are not made to reduce the high unmet need for family planning and slow down the country's rapid rate of population growth which is being fueled by unintended fertility.

The booklet and its accompanying presentation materials are therefore aimed at creating awareness among government and business leaders, community and opinion leaders, other civil society groups and the general public on the consequences of unintended pregnancies and the need to support the population policy and related programmes in order to facilitate the process of national development planning and implementation of programmes.

Rapid population growth and the unmet need for family planning if not addressed adequately and urgently, will have a number of detrimental effects on development and quality of life in Ghana. As a result of continued rapid population growth, in 10 years, i.e., by 2015, Ghana will have to increase its entire infrastructure for food production,

access to health services, education, housing and other services to maintain today's current services. For example, to achieve the MDG of universal access to primary education, it will cost the nation almost $96m or 864 billion cedis. This amount exceeds the amount spent by the GETFUND in financing education at all levels in 2004 by 12.9 billion.[1] In addition, unemployment will also increase because the creation of new jobs required (254,531) might not keep pace with the growth of the labour force.

In short, rapid population growth will make the already challenging task of improving the quality of life in Ghana through economic growth and wealth creation even more difficult. To raise living standards, as has often been stated, the rate of economic growth needs to exceed the rate of population growth upwards of 6 -7 percent[2].

This document examines the impact of rapid population growth on development and illustrates how a successful population management programme would provide significant economic and social benefits to the nation, thereby improving the quality of life for all Ghanaians, especially mothers and children.

'The successful implementation of the revised population policy objectives is dependent on the determined effort and continuing partnership between the Government of Ghana and its constituent institutions, the private sector, non-governmental organizations, donor agencies and more importantly the people of Ghana'.

Source: Government of Ghana: National Population Policy (Revised Edition, 1994). NPC

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[1] ISSER. The State of the Ghanaian Economy in 2004. University of Ghana, Legon.
[2] Government of Ghana and UNFPA. State of Ghana Population Report2003: Population, Poverty and Development. 2004. Accra

2.0 Ghana's Population Dynamics

2.1 Population Growth in Ghana

Figure 1. Historical Population Growth in Ghana, 1921-2004

In 1921, the Ghana census recorded a population of 2.3 million. By 1960 when the first modern census was organized, the population had increased to 6.7 million and the last census in 2000 recorded a population of 18.9. (See Figure 1). Thus over the 79 year period between 1921 and 2000, there was more than an eight-fold increase in the population of Ghana with an average annual growth rate of between 2.3 and 2.7 per cent.

Source: Ghana RAPID presentation, PIP, University of Ghana, Legon

The 2.7 per cent annual growth rate recorded between 1984 and 2000 implies a population doubling time of about 26 years compared to average doubling time of 170 years for developed countries. This represents one of the highest population growth rates in the world and is largely the result of the high level of fertility which has been carried over from pre-modern times to the modern era.

2.2 Population Age Structure

One major demographic consequence of high fertility in the societies in which it persists is that the population tends to be youthful or young. A young population is defined as a population in which more than 20 per cent of the population is below 15 years. On the other hand the population is considered 'old' if more than 10 per cent is above age 64. The median age is another measure of whether a population is young or old. Populations with a median age of under 20 years are usually described as young while those with medians in the range of 20-29 are 'intermediate' and those with medians of 30 or higher are considered 'old'.

The proportion of the population under 15 in 2000 was 41.3 per cent while that of those aged 65 and over was only 5.3. Using the median as a measure of youthfulness, the

median age of the population of Ghana in 2000 was 19.4 (19 for males and 20 for females), slightly up from 18.1 years in 1984[3].

The differences in age structure as a result of differences in fertility levels are clearly illustrated in the chart below which shows the heavy concentration of the population in the middle and older ages for the United Kingdom compared to that of Ghana with the heaviest concentrations in the younger ages as a direct consequence of the past history of high fertility.   (See figure 2 below).

Figure 2. Comparing Ghana's Population Age/ Sex Structure to the United Kingdom
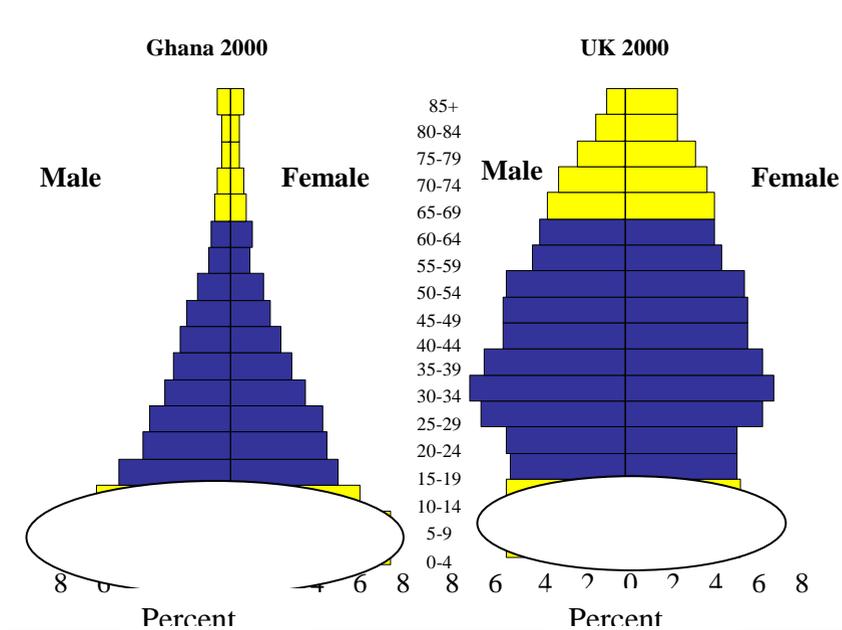
Source: Ghana RAPID Model

Ghana's young population has several implications for current as well as future population dynamics. The median age of first marriage and for sexual debut for Ghanaian women age 20-49 years is 19.6 and 18.2 years[4]. Early age at first marriage is an important fertility indicator because it determines the length of time a woman is exposed to the risk of pregnancy, and also identifies the risk of early childbearing and higher fertility.

The number of women of reproductive age 15-49 years in Ghana will grow from 4.52 million in 2000 to 6.67 million by 2015. It should be noted that the higher the number of women of reproductive age, the faster the population will grow. The combination of continued early childbearing, a larger population of women of reproductive age, and a slower decline in fertility means that it will take some time for Ghana to reach replacement-level fertility.

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[3] GSS. 2000 Population and Housing Census: Summary Report of Final Results. March 2002
[4] GDHS 2003

For example, Gaisie[5] has noted that the age structure tends to maintain relatively high population growth rate even though fertility is falling.   And even at replacement level with a TFR of 2.1, population momentum will lead to expansion of the population by two-thirds its size before growth ceases.   Japan for example reached replacement level in 1957, but its population is projected to grow until 2006.

2.3 Population Growth in the pre-Independence period

High fertility was a characteristic feature of most traditional societies as a result of a combination of pro-natalist beliefs and customary practices.   Until fairly recently, Ghana's fertility conformed to this pattern in a society which was predominantly rural, agrarian and organized along traditional kinship lines.   Low school enrolment, low literacy and low expectation of life reinforced and sustained these values.   The high fertility of the early period was matched by fairly high mortality levels which meant that the resulting population growth was moderate especially as occasional food shortages, pestilences or conflicts periodically led to sharp increases in mortality.

In response to improvements in public health measures, medical services, personal care, hygiene and higher levels of literacy, school enrolment and nutrition, crude death rates began to decline steadily thus widening the demographic gap between births and deaths and resulting in a significant increase in the rate of population growth.   These changes started in the early twenties but intensified during the post-war period.   (See figure 3 below)

Figure 3: Crude Birth and Death Rates, 1955-2004
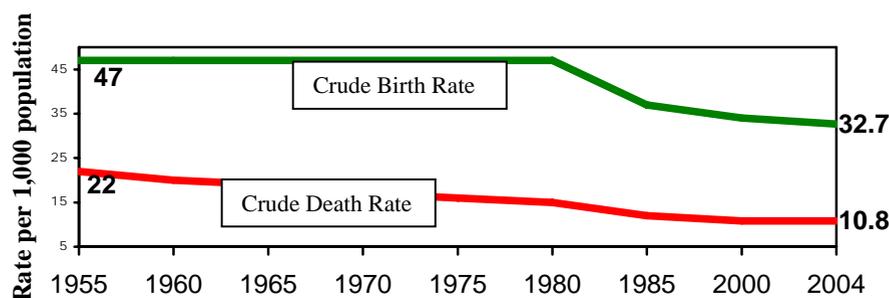
Source: PIP, Ghana RAPID Model

Figure 3 above shows that from a high of 22 deaths per 1000 population in 1955, the crude death rate (CDR) had dropped substantially to 10.8 by 2004. The crude birth rate (CBR) on the other hand remained nearly constant at 47 births per 1000 up to 1980 before dropping to 32.7 by 2004.   The difference between the CBR and CDR which demographers refer to as the rate of natural increase, is a measure of how rapidly the population is growing.

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[5]S.K. Gaisie. 2005. Fertility Decline: Implications for Public Policy. A presentation made at the Population Association of Ghana Seminar. Accra. Ghana. October.

2.4 Fertility and Ghana's Demographic Transition

The available evidence seems to indicate quite clearly that Ghana's fertility behaviour has begun to change. Data from the GDHS shows that Ghana's TFR has declined from 6.4 in 1988 to 4.4 in 2003, meaning a remarkable decline of 2 children per woman within 15 years. The 2003 GDHS TFR of 4.4 is even higher than "wanted" fertility which was 3.7 children per woman. This means that the prospects for further declines in TFR are fairly high if the right programmatic structures are put in place.

In spite of the apparent decline in TFR, the level of fertility still remains high. The CBR of 32.7, CDR of 10.8 per 1000 population and high inter-censal population growth rate of 2.7 per cent indicate that the country is transiting from the first stage of the demographic transition, where both birth and death rates are high to the second stage where a stable birth rate and a declining death rate, lead to a rapid rate of natural increase in population.

2.5 Transition from Phase II to III

The experience of many other countries has shown that there is no short cut from Phase II to III of the demographic transition when both birth and death rates are declining and population growth is as a consequence minimal. In order to fast track this stage of the transition, Ghana will require a significant decline in overall fertility to counteract the effects of the high birth rate of the past. The high birth rate of the past has already built in the population a momentum which is reflected in a high dependency ratio and a large cohort of young prospective fathers and mothers who will continue to fuel population growth for several decades and thus undermining long-term development efforts.

Certain aspects of Ghana's demographic transition are consistent with what has been termed the "cultural lag" hypothesis[6]. Fertility has begun to decline first among the urban and educated elite as manifested in the TFR for the Greater Accra Region and is expected to decline later among the rural population over a long period. In the 2003 GDHS, the TFR for Greater Accra was 2.9 as against 7.0 in the Northern Region. Urban fertility was 3.1, compared to 5.6 for the rural area. Similarly, among women with higher education (secondary school and above) fertility was only 2.5 compared to an average of 6.0 children for those with no education.

Figure 4 below presents the changing fertility and contraceptive use over the past four demographic and health surveys conducted in Ghana. Examination of the four Ghana Demographic and Health Surveys, 1988-2003 by women's age shows that fertility has declined more rapidly among certain age cohorts. Between 1998 and 2003 GDHS,

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[6] Cited in report prepared by National Population Commission (Nigeria), 2003. Population and Quality of Life in Nigeria, 1st Edition. Abuja.

women of ages 15-19 and 20-24, experienced a 41% and 32% decline in fertility respectively[7].

Although women aged 25-29 also experienced fertility declines in the mid-1980s and 1990s, this decline has stalled in the last three years.. Given the recent trends of stagnating TFR and population momentum, low crude birth rates and a slowing of population growth will take some time to be realized. Ghana will therefore have to remain steadfast and vigilant in implementing its population, reproductive health and development policies.

Figure 4
TFR and and use of any and modern contraceptive methods,

Ghana 1988-2003
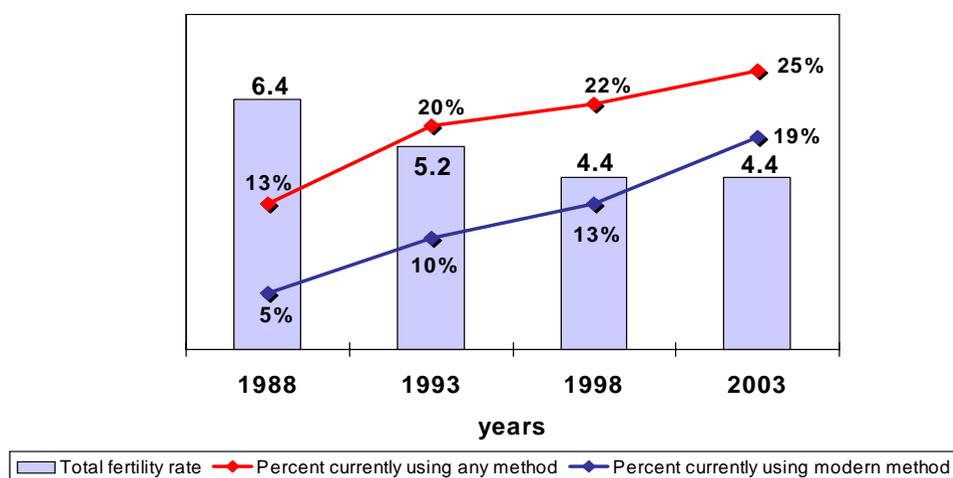
Source: USAID Draft Report: Repositioning FP: Ghana Case Study. Dec., 2004

2.6 Contraceptive Prevalence and Fertility: Efforts at Repositioning FP

Ghana continues to make progress in reducing the overall level of fertility among married women and contraceptive prevalence has been on the increase, as illustrated by Figure 5. In 2003, findings from the GDHS indicate that the country is on course to achieving the earlier TFR target of 4.0. As already indicated, TFR is now 4.4. The comparable contraceptive prevalence rate goal as stipulated in the Population Policy is 28 percent by 2010 and 50 percent by 2020. The achievement of these targets is recognized as an integral part of the country's national strategy of economic development as outlined in the Ghana Poverty Reduction Strategy (GPRS).

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[7] GSS/NMIMR and ORC Macro. 2004.Ghana Demographic and Health Survey 2003. Calverton Maryland.

Figure 5. Contraceptive Prevalence Rates (Modern Methods) in Selected African Countries
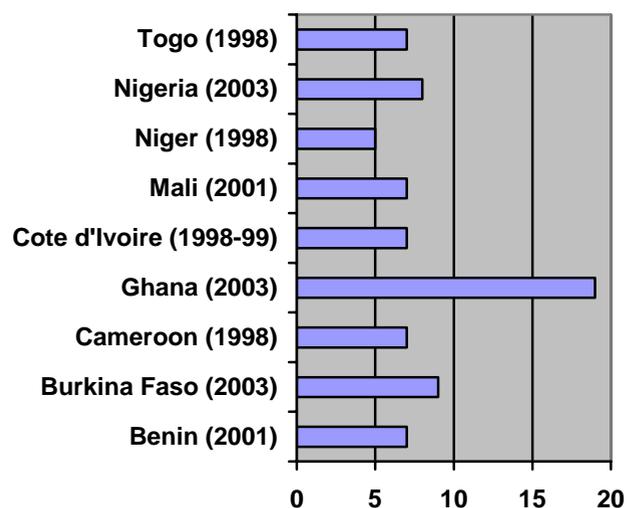
Source: Ghana Demographic and Health Survey (GDHS 2003). Fact Sheet.

Although Ghana's population growth rate ranks among the highest in the world, evidence from the 2000 census indicates that it has slowed down somewhat from 3.0 percent to 2.7 percent between 1984-2000. Growth rates of over 2.5 percent per annum undermine and frustrate the attainment of national development objectives. Ghana's moderately high population growth rate thus constitutes the basis for the continuing deep concern about the country's demographic structure and the fear that a point will be reached when future generations will be born into a country in which their very numbers condemn them to life-long poverty and misery.

Family planning can slow down the rapid growth of the population. The benefits of family planning actually extend beyond slowing the pace of population growth. By using contraception, women can avoid the high risk of poorly timed pregnancies that jeopardize their health and that of their children. Ghana, like other developing countries beset by high maternal and child mortality rates have the most to gain from family planning's numerous health benefits (such as reducing a woman's exposure to unintended pregnancies, reducing the number of abortions and abortion related complications among several others).

However, any effort to promote family planning must first ensure that the large numbers of women and men who already want to space and limit their births are able to do so. According to the 2003 GDHS, Ghana has one of the highest levels of unmet need (22% spacing and 12% for limiting - making a combined total of 34 percent). This is despite the country's best efforts as indicated by a moderately high CPR of 19 percent.

Efforts are also being made to re-position family planning. As an outcome of the Africa Regional Conference on Re-positioning FP, held in Accra, a national technical team was

constituted to develop a national strategy on re-positioning FP for Ghana. The National Strategy document has been completed. The vision of the strategy is to increase awareness of and commitment to integrate family planning as an essential component of national health and development goals. The strategy also focuses on seven (7) key strategic areas, namely, Advocacy/BCC/IEC, policy/operational guidelines, institutional coordination and collaboration, human resource, improved access to family planning service delivery, expanded resource mobilization and research and monitoring and evaluation.

The policy objectives of Government are the continued decline of the total fertility rate through the increase of CPR and decreasing unmet need for contraception. From the GDHS findings, unmet need has remained unchanged in the five-year intervening period, 1998-2003. Policies and strategies to address this high unmet need include providing access to a wide range of quality FP services and methods through public and private channels; dual protection through condom promotion; improving IE&C with emphasis on BCC and individual counselling and education.

3.0 Challenges of Population Growth in Ghana

There are strong links between rapid population growth, high fertility, ill-timed pregnancies and poverty – a demographic-related poverty trap exists. And, indeed, demographic trends affect development prospects.

Source: The Millennium Project -"Investing in Development". Population, Reproductive Health and the Millennium Project: Summary of Population & Sexual and Reproductive Health Recommendations. Jan., 2005.

3.1 Population Growth Challenges for Ghana in Achieving the MDGs.

In September 2000, 147 heads of state and governments, and 189 nations in total, committed themselves to the Millennium Development Goals (MDGs). The MDGs stand for a renewed commitment to overcome persistent poverty and address many of the most enduring failures of human development. The eight MDGs include:

- ❑ Eradicate extreme poverty and hunger
- ❑ Achieve universal primary education
- ❑ Promote gender equality ad empower women
- ❑ Reduce child mortality
- ❑ Improve maternal health
- ❑ Combat HIV/AIDS, malaria and other diseases
- ❑ Ensure environmental sustainability
- ❑ Develop a global partnership for development

Recently, the FUTURES Group[8] did a simple analysis of how fulfilling the unmet need for family planning can help countries to achieve the Millennium Development Goals (MDGs) as part of the preparations for the Regional Conference on Repositioning Family Planning held in Accra in February 2005. The report focused on four countries - Ghana, Nigeria, Madagascar and Mali.

Figure 6. Women who want to use family planning
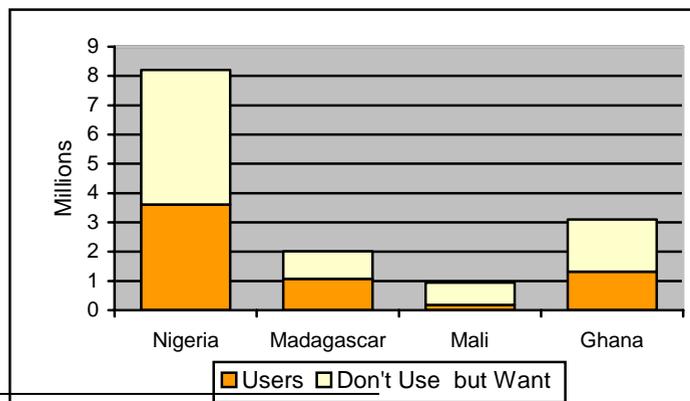
Figure 6 shows that in Ghana, the number of women who want to use family planning but are not currently using (1.8 million) exceeds the number of women using family planning. These data suggest promising prospects for future contraceptive use, although uptake of use will likely be

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[8] Source: Scott Moreland and Jean-Pierre Guengant. Feb 2005.
Scott Moreland and Jean-Pierre Guengant. Achieving the Millennium Development Goals. The Contribution of Fulfilling the Unmet Need for family Planning. February 2005.

slow. The National Population Council, the Ghana Health Service, and other partners must strengthen their efforts to respond to this explicit need for family planning. Policy makers in all sectors need to respond to this unmet need in order to address the fertility preferences and health needs of these women, and in doing so, address the population growth issue and contributing to the achievement of the MDGs.

Figure 7. Achieving Universal Primary Education in Ghana
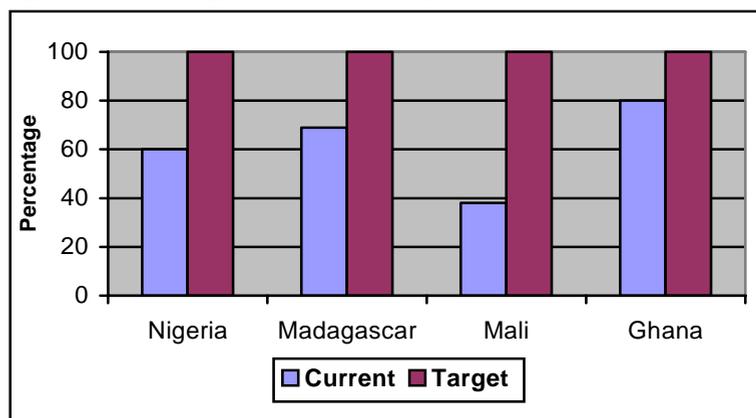
The Millennium Development Goals emphasize the need to achieve universal primary education, for boys and girls, by 2015. The implementation of Ghana's Education Strategic Plan (ESP) has led to the increase in enrolment at the primary school level. As shown in the chart above, the National Gross Enrolment Ratio (GER) was 80 percent in 2000/2001, and this has since increased to 86.1 percent by 2003/04. The Gender Parity Index is also 0.93.

Reducing population growth by fulfilling unmet need for family planning will generate savings to the education sector by $43 million dollars as shown in Figure 8. The calculation is based on the assumption that all women who currently have an unmet need for family planning will begin using contraceptives and current users will continue to use contraceptives.

Figure 8. Cumulative Primary Education Cost Savings in Ghana due to fulfilling unmet need
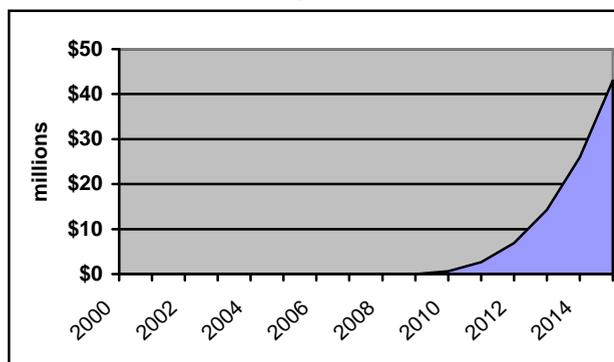
Source: Scott Moreland and Jean-Pierre Guengant, Feb. 2005

3.1.1 Maternal Health

The maternal mortality ratio in Ghana has changed little in recent years, with estimates ranging from 214 to 742 deaths per 100,000 live births and higher in certain areas[9]. The pregnancy complications that cause these deaths include sepsis, haemorrhage, hypertensive disorders of pregnancy, obstructed labour and abortion complications. For every girl and woman who dies, many more will suffer short and long-term disabilities such as fistula, a ruptured uterus, or pelvic inflammatory disease. In addition early

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[9] B. Ababio and P. Antwi . Policy Implication of Maternal Mortality in Ghana. Maternal Mortality as an Indicator of Progress in Health Sector Reform. Draft. Nov. 2001.

neonatal deaths and stillbirths are caused by the same factors that cause the death and disability of their mothers, as well as lack of newborn care.

One significant contributing factor to maternal mortality in Ghana is the failure to effectively use contraception. Unsafe abortion is an important cause of maternal death, contributing between 20-30 percent of maternal deaths in Ghana. This means many girls and women are dying of pregnancies they did not want. The 2003 GDHS reinforces this finding, revealing that one in three women currently do not use a contraceptive method even though they express the desire to space or limit births. Furthermore, the gap between Ghana's actual birth interval and women's preferred birth interval is one of the largest in Sub-Saharan Africa.

Another critical factor in maternal mortality is clearly the lack of essential obstetric services. It is notable that over 80% of pregnant women in Ghana seek antenatal care from skilled attendants, although the quality of these services varies. However, fewer than half of pregnant women have their deliveries supervised by skilled attendants, and the proportion has actually decreased in some areas as evidenced in the 1993 and 1998 GDHS. In the 2003 GDHS, nationally, supervised delivery by a skilled attendant was 47 percent - less than half of all deliveries. Medically assisted deliveries therefore continue to be low in Ghana.

If the unmet need for family planning is achieved by 2015 in Ghana, 4,419 maternal deaths would be averted due to a reduction in unwanted pregnancies over the period, 2000 to 2015.

Figure 9: Fulfilling Unmet Need Reduces the Number of Maternal Deaths in Ghana and Selected African Countries: Maternal Deaths Averted due to Reduced Pregnancies, 2000 - 2015
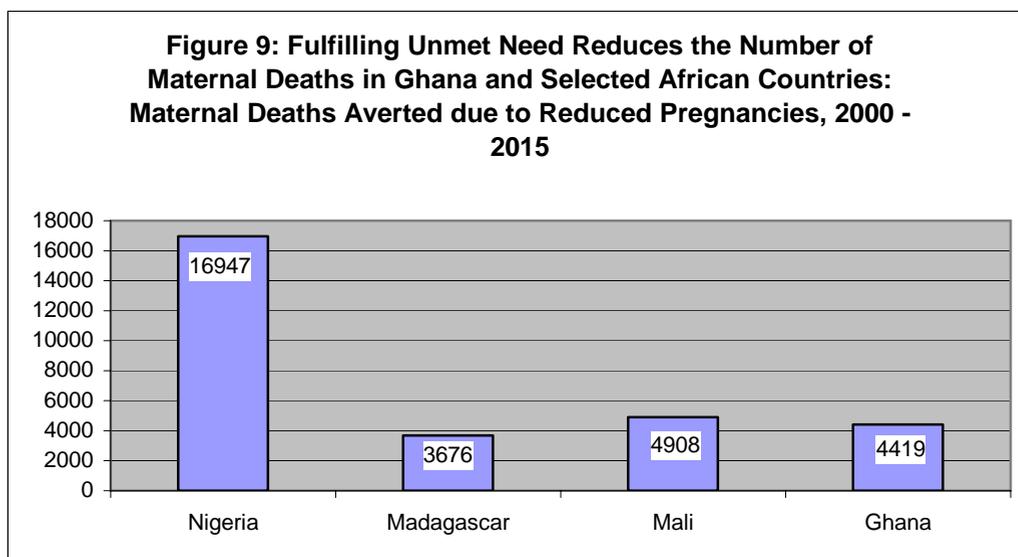
Source: Scott Moreland and Jean-Pierre Guengant. Feb. 2005

Meeting the MDGs for maternal health is a huge challenge, especially given that there is no formal comprehensive national maternal health policy in Ghana. However, the government is committed to improving maternal health and this is reflected in a

combination of laws, formal sectoral policies, regulations, program actions and the resource allocation patterns and leadership of the government. In 1997, Ghana initiated a health sector reform effort and uses the maternal mortality rate as an indicator of health status. Ghana promotes the theme of Safe Motherhood, following an international conference on the subject in 1987. Among the formal policies adapted to support this theme was the 1996 National Reproductive Health Policy and Standards which includes a target of reducing maternal mortality by half by 2001, a goal that has yet to be achieved. A greater effort must be made to achieve the MDGs of reducing maternal deaths by three-quarters in Ghana by 2015.

3.2   Challenges for Individual and Family Health

Population growth and size are influenced by the three components of population change - fertility, mortality and migration. Fertility, in turn, is a function of the collective reproductive health choices and behaviours of individuals and couples. More importantly, individuals and families feel the impact of high fertility at the national, sub-national and community levels. This analysis will focus on the individual and family level impacts. For example, at the family and individual levels, one of the most important impacts of high fertility is increased infant and child mortality.

3.2.1 Infant and Child Mortality

Another remaining challenge at the individual and family level is reducing infant mortality by ensuring that births are well spaced and early births are postponed. Unfortunately, Ghana has begun to see a reversal in the gains made in the past in addressing infant and child mortality. The 1998 GDHS showed a decline in this critical health indicator, dropping from a high of 66 infant deaths per 1,000 live births in 1993 to 57 in 1998. In 2003, infant mortality had increased to 64 deaths per 1,000 live births.

Under five mortality in Ghana is 111 deaths per 1,000 live births in the 2003 GDHS and this means one in every

Figure 10. Trends in Infant and Under Five Mortality Rates, Ghana, 1988-2003

nine children dies before reaching age five. As the infant mortality rate indicates, nearly three in five of these deaths occur in the first year of life. (see Figure 10 below).

The increase in infant mortality is attributed to an increase in the neonatal mortality rate, which increased from about 30
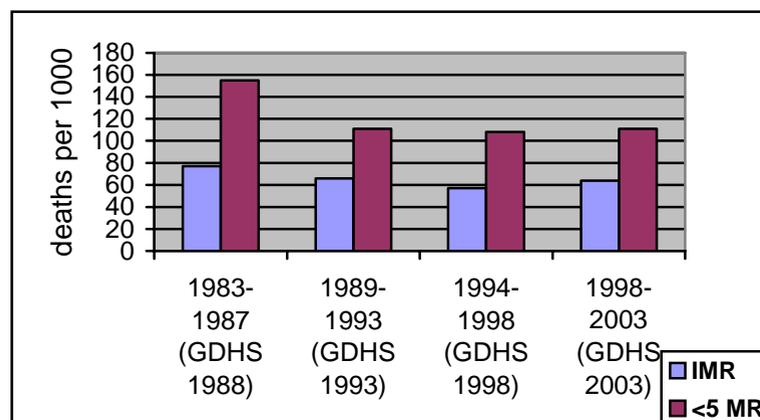
per 1,000 in the 1998 GDHS to 43 per 1,000 in the 2003 GDHS[10].

This apparent stagnation in mortality decline signifies the difficult challenges the population is faced with in trying to overcome socioeconomic, fertility, and health system challenges. The Ghana Population Reduction Strategy 1 sets targets for reducing infant and under-five mortality rates to 50 per 1,000 and 95 per 1,000, respectively, by 2005.

When projecting fertility and infant mortality rates, the age at which a woman gives birth, the time between births, and the birth order are critical factors in determining the health and survival of a baby. Pregnancies in women who are too young (under age 18) or too old (over age 35) lead to higher infant and maternal mortality. Children born to mothers younger than 18 years are at a particularly high-risk, almost twice the risk of those not in any high-risk category. This is because the body of a woman under 18 years of age is still too immature for pregnancy and childbirth. Young mothers are also more likely to be anaemic than other mothers, and a teenage mother's body will compete with her growing fetus for essential nutrients. Figure 11 shows the number of infant deaths per 1,000 live births according to the age of the mother. Although the safest time to have a child is between 20-29 years of age, more than a third of all births in Ghana are born to women outside of this age range.

Figure 11. IMR by Age of Mother at Birth, 2003
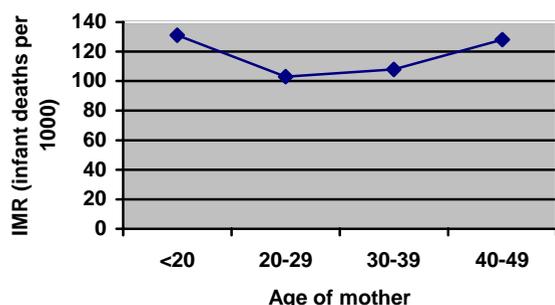
Figure 12. IMR by Birth Interval
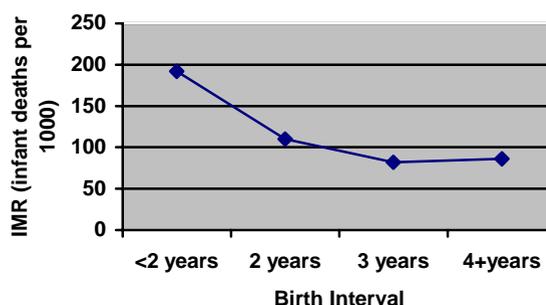
Figure 13. IMR by Birth Order

Source. 2003 GDHS
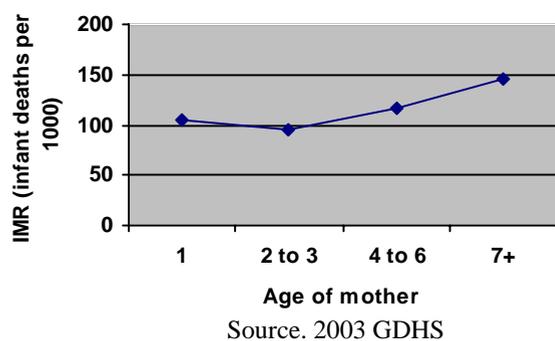
Infant mortality risks are also higher when births are too close together (<2 years), as illustrated in Figure 12. From the recent GDHS, children born within two years of a prior birth are twice as likely to die as those born three or more years apart. When such births are too close together, a woman's body does not have adequate time to recover from the physical stress of the previous pregnancy and childbirth, thereby reducing her chance of delivering

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[10] GSS/NMIMR and ORC Macro. 2004. Ghana Demographic and Health Survey 2003. Calverton Maryland.

a healthy baby. Close spacing can also reduce the number of months a mother breastfeeds her child.

High birth order is also an important contributing risk factor for infant mortality. In Ghana, the seventh and higher order child in a family is twice as likely to die in infancy than the second or third child, as shown in Figure 13 above.

The prevention of these premature deaths and illness among the various high-risk mothers and children is a key objective of both the National Population policy and the National Reproductive Health Policy and Standards produced by the MOH/GHS. The Ghana Health Service, however, is challenged in making the necessary services available to women and children in order to prevent these avoidable deaths. Population growth puts an increased burden on the health system as more and more women and children access maternal and child health services.

4.0 Impact of RAPID Population Growth on Development Sectors

Rapid population growth rate is among the factors that contribute to the persistence of poverty and underdevelopment in Ghana, making a significant impact on key development sectors. This is recognized in Ghana's Poverty Reduction Strategy (GPRS), as described in box 1.

Box 1. Overview of Ghana's Poverty Reduction Strategy (GPRS)

The Ghana Poverty Reduction Strategy (GPRS) is the key development policy framework for the country. The implementation of the GPRS, which began in 2002, is geared toward achieving the medium term priorities of the Government. With an increased awareness of the importance of the GPRS, it has been used to inform all key policy and budgetary decisions both at the national and the district levels.

The Government of Ghana is now set to begin the implementation of the GPRS II. The new strategy aims to reach middle-income status by 2015, and also achieve the targets of the Millennium Development Goals. Other programme goals include the following:
  ⇒ continued macroeconomic stability,
  ⇒ accelerated private sector-led growth,
  ⇒ vigorous human resource development and
  ⇒ good governance and civic responsibility.

At the recent third consultative meeting held between the Government of Ghana and its development partners, including the World Bank, IMF, the European Union, the United States Government and others, the Government pledged to release $1.2 billion annually or a total of $5.0 billion over the next four years to implement the GRPS II.

In this section, the implications of rapid population growth are discussed under two fertility scenarios; a) a high fertility scenario that projects a fertility decline to 3.6 children per woman in 2015, and b) a lower fertility scenario that projects a decline in fertility to 3.0 children per woman in 2015.

Figure 14. Population under two fertility scenarios
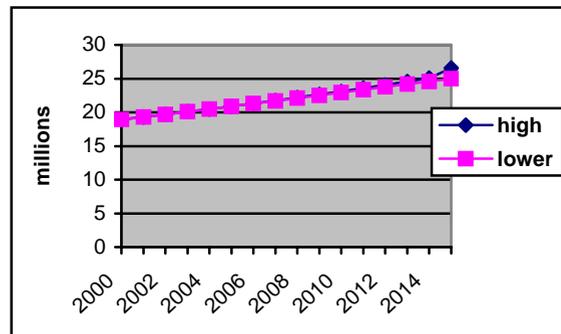
The high fertility scenario is indeed consistent with the targets of the revised National Population Policy of 1994, and the lower fertility scenario is modeled to achieve lowered fertility five years earlier. This could be feasible given that Ghana has recently made demonstrable achievements in meeting fertility goals - TFR is already down to 4.4 children, which is ahead of the target set in 1994.

Figure 14 above shows the impact of these fertility rates on population growth. Under the high fertility scenario, Ghana's population will reach 26.6m by 2015 compared to a smaller population size of 24.9m in 2015, if fertility declines to 3.0 children per woman.

4.1 Health

The Ministry of Health/Ghana Health Service (MOH/GHS) 5 five-year Programme of Work (POW) covering 2002-2006 provides the framework for the Government of Ghana's agenda for improving the health status of all Ghanaians and reducing inequalities in access to services. The POW thus represents the health sector response to the Ghana Poverty Reduction Strategy (GPRS) and aims to contribute towards the **'creation of wealth through health'**.

Currently, it is estimated that 27% of the Ghanaian population is considered to be very poor and at high risk of not having access to basic health services. In addition, the National Health Insurance Scheme (NHIS) is only reaching fewer than 10% of those most in need of the service. Increasing access to health services, especially for the poor requires adequate health manpower, which is currently on the decline.

Achieving comprehensive health care coverage while the population continues to grow rapidly will require that the government allocate an ever-increasing share of human, physical and financial resources to health care. Family planning, by reducing the rate of population growth and helping couples to space or limit births, will improve the health of children and mothers, and will dramatically reduce the cost of providing health care in Ghana.

4.1.1 Health Care Manpower

If fertility remains high, and Ghana's population continues to grow at the current rate, by 2015, the government will have to provide many more doctors and nurses to service the health needs of the population. Under the high-fertility scenario, assuming the doctor-population ratio stays the same, the required number of doctors will need to grow from 1,080 in 2000, to over 1,420. Currently, the doctor-to-population ratio is already very low; in 2000 there was one doctor to every 19,618 people. Under the high fertility scenario 1,420 doctors will be needed in 2015, compared to 1,370 needed under the low fertility scenario. Similarly, fewer nurses will be required in 2015 (18,550) under the low-fertility assumption than would otherwise be needed if the population continues to grow at a high rate (nurses required will be 19,200).

Figure 15. Trend in Loss of Trained Public Sector Health Staff, 1993 - June 2004
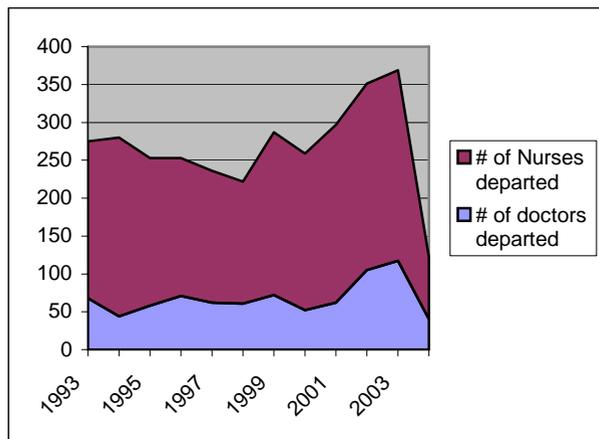
Source: HRDD/MOH, 2004 as quoted in WHO Ghana Office,
Annual Report, 2004

The challenge of recruiting and training a sufficient number of health care staff is further complicated by the fact that Ghana suffers from 'brain drain' of staff from the health sector, as well as other sectors, as illustrated by Figure 15. This could compromise the ability of the NHIS to increase access to health and to bridge the financing gap needed to improve equality in the provision of health services to all Ghanaians. The need for increased health sector resources such as doctors and nurses demonstrates the potential impact of fertility on the health sector.

Box 2. Ghana on course to meet Millennium Development Goals

Despite widespread pessimism, Ghana and some other African countries are on course to meet key goals, according to a new report on the Millennium Development Goals published by the UN Economic Commission for Africa (ECA). The report also indicates that the MDGs have served as a catalyst to spur sluggish programmes that can bring Ghana and other countries on the continent closer to achieving their development aims. And where the right policies are not in place, the goals can provide new impetus to reverse the deterioration in human development.

Source ECA 2005. "The Millennium Development Goals in Africa -- Progress and Challenges,"

4.2 Impact of HIV/AIDS on Childhood Survival and Life Expectancy at Birth

In 2003, there were over 400,000 Ghanaians living with the HIV virus that causes AIDS. Given this, there is no doubt that the HIV/AIDS epidemic is having and will continue to have a major impact on Ghana, including its demography.

HIV/AIDS affects the population through mortality and fertility. Without treatment, about 25–40 percent of infants born to HIV-infected mothers become infected either during pregnancy, during birth, or through breastfeeding. Most of these children will develop AIDS and die within two years, and very few survive past the age of five. As the HIV/AIDS epidemic spreads in Ghana, AIDS will increasingly become a major cause of child death, one that threatens to continue to reverse many of the recent gains made by child survival programmes.

In 2015, approximately 2,500 Ghanaian children under five will die due to the HIV/AIDS epidemic.

One indicator that can be used to assess the impact of HIV/AIDS on child survival is the child mortality rate—the rate at which children born in a given period die before the age of five. Typically, it is expected that child mortality would decline as a nation's health, economic, and environmental conditions improve. However, as a result of HIV/AIDS, it

is estimated that declines in child mortality in Ghana will be more modest over the next 10 years, as illustrate in Figure 16.

Figure 16: Deaths Among Children Under 5-years Old per 1,000 Births, 2000 – 2015
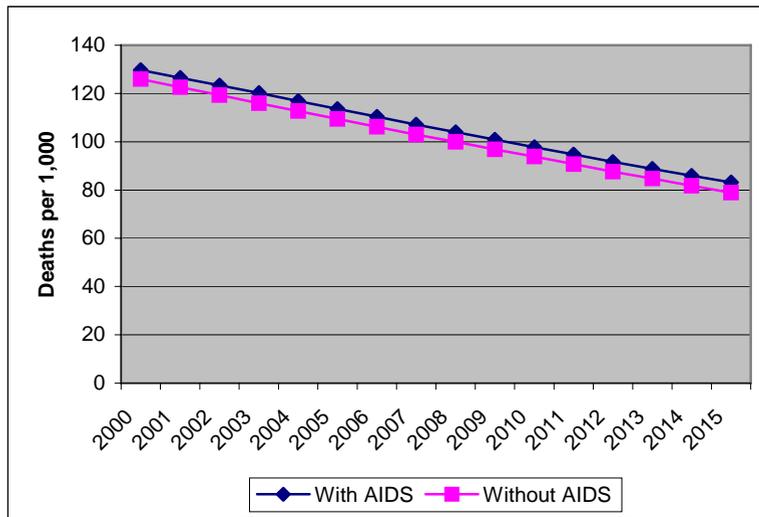
Source Ghana AIM, Sept, 2004

AIDS-related mortality also has a negative impact on the life expectancy at birth in Ghana. Life expectancy at birth is an estimate of the average number of years a child born today may be expected to live given the current age-specific mortality rates. This figure is calculated by determining the proportion of males and females who die at each age from different causes. As such, a large number of deaths of people in their early years in a given society would lead to a low life expectancy at birth, while a society with few deaths at young ages would have a higher life expectancy.

Figure 17. Projected Life Expectancy at Birth, 2000-2015
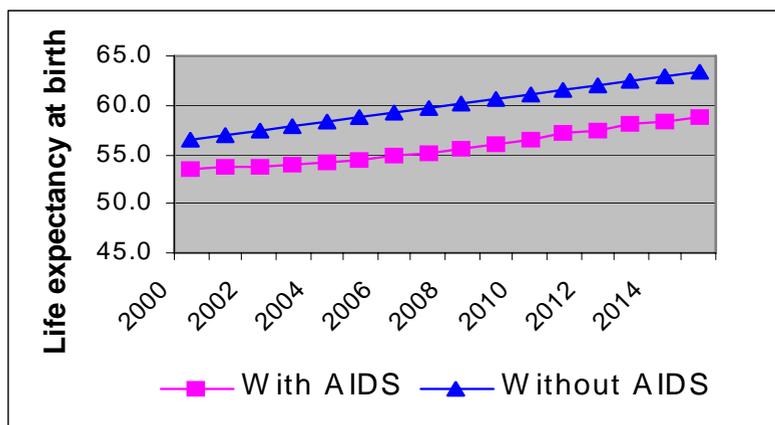
As a nation's economic conditions and standards of living improve, people tend to live longer. The Ghana Statistical Service estimates that in 1984, life expectancy at birth in Ghana was about 50 years. This was before the inception of the HIV/AIDS epidemic. Based on the 2000 census results and the projections model used in this analysis, two scenarios were examined—trends in estimated life expectancy at birth given the current AIDS epidemic, projected trends in life expectancy at birth if there were no HIV/AIDS in Ghana. After 1990, AIDS deaths began to have an impact on life

expectancy at birth, and by 2004 AIDS-related mortality is estimated to have reduced the average life expectancy at birth by four years. Given the current HIV prevalence, this impact could increase to five years by 2015, depending on actual trends in HIV prevalence over the 10 years.

4.2.1 Impact of AIDS on Population Size and Growth

The two factors that primarily determine a country's future population growth are fertility and mortality. Over the last 20 years, Ghana's strong family planning and reproductive health programmes have led to a reduction in total fertility rate (TFR)—the average number of births per woman—from 6.6 children in the early 1980s to the current 4.4 children as reflected in the 2003 GDHS. It is apparent, therefore, that this decline in fertility has contributed to a decline in population growth over the last 20 years and will continue to do so in the future.

There are, however, those who think that the HIV/AIDS epidemic will reduce population growth to the extent that the high rate of population growth in Ghana (put at 2.7% per annum) should no longer be a concern. This is not True! HIV/AIDS will slow, but not stop, population growth. The impact on population growth, and by implication, future population size, is seen in the amount of reduced births and increased mortality among women of childbearing age. This information is presented in figure … below.

Figure 18: Estimated and Projected Population of Ghana (in millions), 2000 – 2015
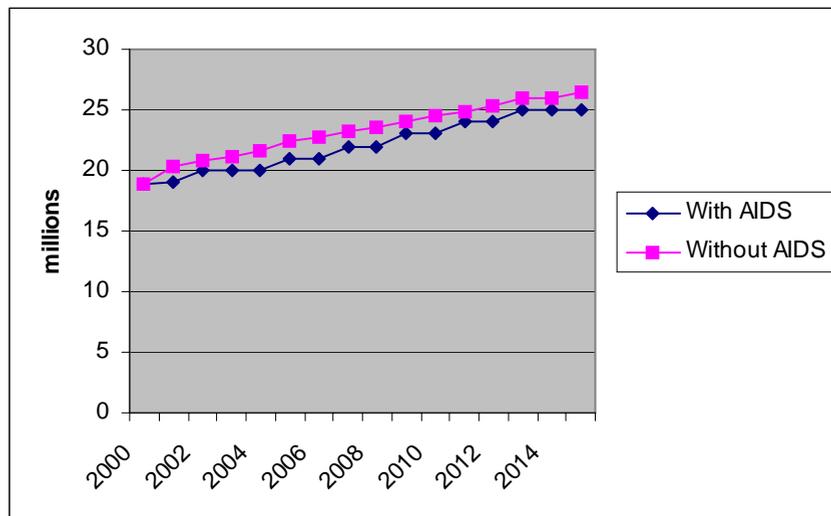
Higher mortality from AIDS can also be expected to impact on the future growth of the Ghanaian population, as it has elsewhere in eastern and southern Africa. The projections shown above assume a continual decline in the total fertility rate over the next 10 years to 3.6 by 2015. This graph compares the projected population of Ghana with and without HIV/AIDS. The results show that by 2004, there would be about one-quarter of a million fewer people in Ghana, principally due to HIV/AIDS. An important point to remember is that this difference mainly represents Ghanaian adults in the productive age groups, who are no longer alive to care for their children and elderly parents, and to contribute to the economic well-being of their communities. However, as shown, the population of Ghana will continue to grow, although at a slightly slower pace.
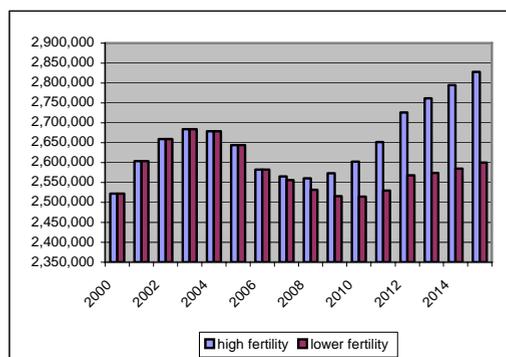
4.3 EDUCATION

The Government of Ghana places high priority on educating children and preparing them to meet the need of a growing technology driven economy. Towards this end, the 1992 Constitution provides that basic education should be free, compulsory and available to all. This led to the launching of the Free, Compulsory and Universal Basic Education (FCUBE) programme in 1996 (aimed at ensuring quality, efficiency and access to education and providing good basic education for all children of school-going age in Ghana.

The gross enrolment rate (GER) for primary school has improved from 75.5% in 1987/88 to 83.8% in 2001/02, and at Junior Secondary School (JSS), the GER was 66.6% during the same period. Gender gap in favour of boys decreased from 10% in 1996/97 to 7% in 2002. For net enrolment, the national average is 58%, representing 59% for boys and 58% for girls in the 2000/2001 school year[11]. The general poverty level in the country is an underlying factor limiting the ability of parents to meet the costs of schooling and school related expenses. However, with the recent introduction of Capitation Grant in support of the FCUBE programme, enrolment has started to pick up in both rural and poor urban communities.

Overall, education expansion to ensure increased access to educational opportunities is a key objective of the Education Strategic Plan (ESP) covering the period 2003-2015. The ESP incorporates the converging objectives of the GPRS, the Education for All (EFA), the MDGs and NEPAD. Among other objectives, the ESP further emphasizes attainment of universal basic education by 2015.

As a result of rapid population growth, the growing number of students will create a surge in the demand for primary schools and teachers well before 2015, as is now being manifested with the introduction of the Capitation Grant. If universal primary enrolment were to be achieved by 2015, enrolment would reach 2,828,106 million students under the high fertility scenario, versus 2,600,268 million under the low fertility assumption, as shown in Figure 19. Correspondingly, the demand for primary school teachers would increase from approximately 66,802 today to well over 88,378 teachers by 2015, as

Figure 19. Number of primary school pupils   **Figure 20. Number of primary school teachers**
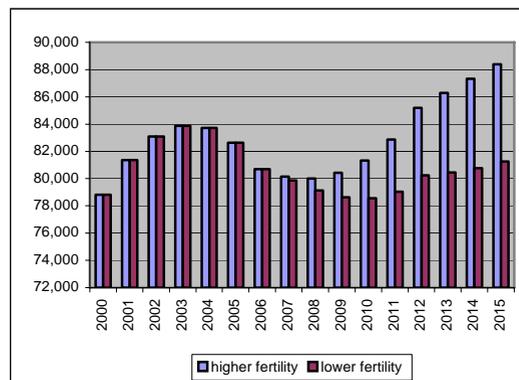
[11] MOES. Education Strategic Plan: 2003-2015. Policies, Targets and Strategies Vol.1.May 2003

illustrated in Figure 20. To meet this high demand for educational opportunities at the primary school level, 16,734 additional classroom blocks will be required.

4.3.1 Expenditure on Provision of Education

Increased educational expenditure will be required to meet the EFA goals for primary education, if all school age children are to be given the opportunity to enrol and remain in school. Looking at primary education alone, by 2015, the Government will have to increase expenditures under the high fertility scenario, spending $96.16 m, compared to $92.99m under the low fertility scenario, as illustrated in Figure 21.

Figure 21. Expenditures on primary education under two fertility scenarios

4.4 ECONOMY

Thomas Malthus's postulate in 1798 of the inverse relationship between population and economic growth remains relevant even up to today. Malthus argued that at the macro-level of entire societies, high fertility was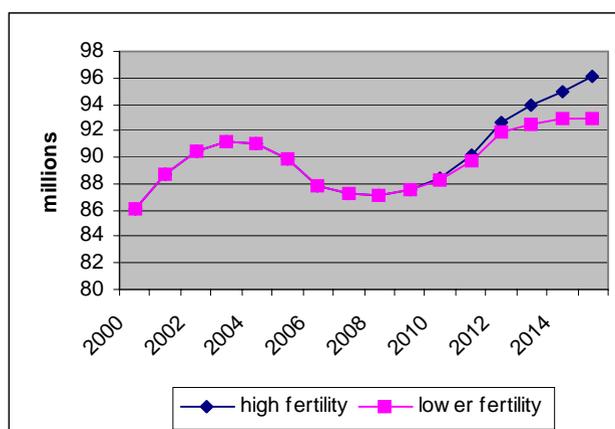 likely to worsen income distribution and increase poverty by increasing the price of food and reducing the price of labour. This position was for a long time, greeted with skepticism until more studies became available. Today, there is a definitive body of knowledge based on careful empirical research that credibly indicates some measurable link between population and poverty. In this section, we look at the impact of population growth on the future size of Ghana's labour force, new jobs required, and the dependency ratio.

4.4.1 Labour Force and Number of New Jobs Required

The potential work force of a nation derives from its adult population that is available and have the right skills to work. Rapid population growth affects the economy and the pool of available persons in the age group 15-64 who can engage in lawful activities to support themselves and their families. According to the 2000 Population Census results, the size of Ghana's Labour Force is put at 10.1 million.

Using the high population growth scenarios of high fertility (TFR of 3.6 in 2015), the size of the labour force is projected to increase by a quarter million additional job seekers into the job market. But because of the relatively long lag, of at least 10-15 years before a change in the TFR can have an impact on the labour force, lower fertility would not have much of an impact on the overall size of the labour force in the short run. Nevertheless,

changes in the TFR would translate eventually into a change in the rate of growth of the labour force and therefore in the number of new people needing jobs. With higher fertility, 255,000 more jobs would need to be created between now and 2015 to keep up with population growth.

Figure 22. Number of new jobs required under two fertility scenarios, 2000-2015
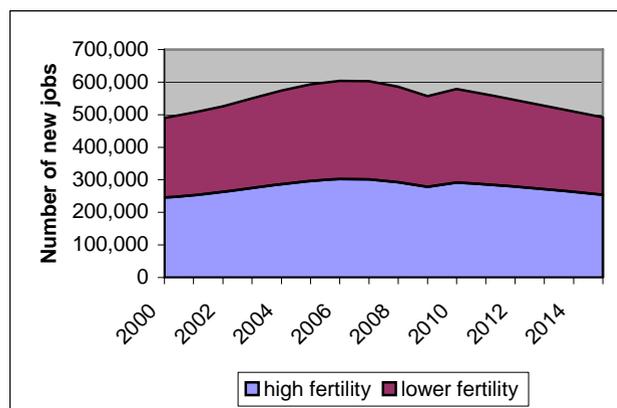
Creating an additional 255,000 jobs for young Ghanaians who will enter the labour force will continue to put strain on the already overburdened economy and the provision of other social services including mass transport services, urban housing etc. Even with the Government's recent focus on human development and job creation, it will take some time to create enough formal sector and well-paying jobs for the quarter million new job seekers each year under the high fertility scenario.

4.4.2 Dependency Ratio, Savings and Investment

Rapid population growth leads to a young population, and a young population leads to a high dependency ratio (i.e., an above-average number of young dependents per economically active adults). Ghana has a predominately young population (see pyramid in early section of report) and its dependency ratio of 87 children aged 0-14 years per 100 adults aged 15-64 is already much higher than that of the more developed nations.

Figure 23 shows Ghana's dependency ratio under both the high and low fertility scenarios.

Figure 23. Child Dependency Ratio: Children 0-14 per adults aged 15-64
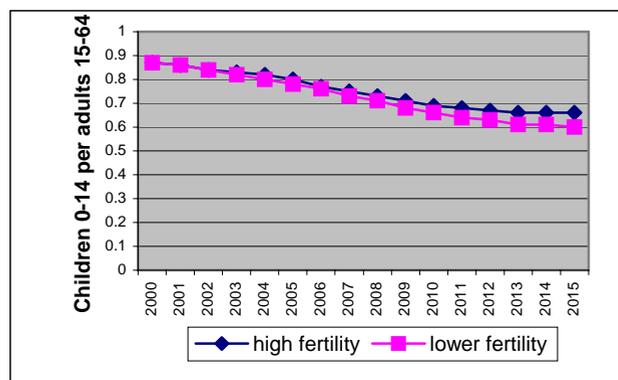
The dependency ratio projected under the high growth scenario (TFR=3.6) has many implications for Ghana's economic development and the attainment of middle income status as indicated in the GPRS II. As in most developing countries, the high cost of providing social services for a large non-working population is to a greater extend, borne by a much smaller working population. Even at the household level, there are relatively few working adults providing for the basic needs of many children, including a

growing number of orphans, as well as other non-working household members. A common refrain often heard from workers is '*we don't have money in our pocket*'. In large families where household resources are spread over even more family members, the quality of life for each member decreases as a result.

The economic consequences of a high dependency ratio at both the household and national levels are lower savings due to increased spending and consumption and lower investment. This is important because savings - *capital formation is a prerequisite for development.* In 2000, the gross national savings (as a percent of gross national **i**ncome) was 13 percent compared to 23 percent for the rest of the world[12]. In general, significant economic development will only occur if the savings rate is over 20 percent; above 25 percent it is classified as "good" and "very good" if above 30 per cent[13].

With high fertility, rapid population growth, and a high dependency ratio, resources will be diverted from investment in new capital, to capital maintenance and labour costs. Lower investments would lead to lower productivity and low per capital income.

In the recent publication on the State of Ghana's Population[14], due recognition has been given to sustained economic development brought about by capital formulation as one of the primary routes to effective poverty reduction.

The 'Asian Tigers' comprising Indonesia, Thailand, Singapore, Malaysia, South Korea etc., are often cited as having taken advantage of their demographic dividends in the early 1960s to the late 1990. These countries made prudent investments in population management, health, education and nutrition and technology etc., and this has helped them in achieving high economic growth rates. The low dependency ratios that resulted from low population growth contributed to the accumulation of physical and human capital thereby ensuring that fertility declines kept pace with economic growth.

Similarly, strong sentiments have been expressed recently regarding Ghana's potential to emulate the example of the Asian Tigers (see Box 3).

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[12] World Bank: World Development Indicators 2002.

[13] Hans-Gert Braun. A Possible Means of Encouraging Development: Mobilisation of Savings Capital in Third World Countries. May, 2003.

[14] Government of Ghana and UNFPA. State of Ghana Population Report 2003: Population, Poverty and Development. 2004. Accra.

Box 3: Former State Dept. Official Sees 'Five African Lions'

Ghana, Nigeria, Tanzania, Kenya, and South Africa could rival "Asian tigers" like South Korea by 2015, says former Assistant Secretary of State for African Affairs Herman J. Cohen.

In a Washington File interview October 6/05, Cohen, who was Assistant Secretary of State for Africa from 1989 to 1993, said he expects "good things" from the "five African lions," including consistent gross domestic product growth of 7 percent or more a year. Ghana has already projected a GDP growth of 6 percent for 2006, well on its way, it would seem, towards the achievement of this target.

In the 1960s, Hong Kong, Singapore, South Korea and Taiwan were at comparable levels of wealth as African countries, Cohen said. Since that time, the "four Asian tigers" have experienced astonishing rates of sustained growth, while their African counterparts, for the most part, have stagnated.

Cohen said he believes the trend is reversible, provided the lions return to their agricultural strengths and maximize their inexpensive labor force through manufacturing.

These potential African lions also illustrate current US policy of "backing winners" -- a strategy that concentrates "the lion's share" of U.S. development assistance on those countries most likely to "roar," says Cohen. Ghana, for example, is currently set to receive assistance under the President's Millennium Challenge Corporation (MCC), which provides development assistance to those countries that rule justly, invest in their people and encourage economic freedom.
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Source: The Washington File is a product of the Bureau of International Information Programs, U.S. Department of State. Web site: http://usinfo.state.gov.

4.5 AGRICULTURE AND FOOD SECURITY

The agriculture sector has always been the largest sector of the Ghanaian economy. It consists of four main-sectors, namely crops and livestock; cocoa; forestry and logging and fisheries. The importance of the agriculture sector in the economy cannot be over-emphasized since over 60 percent of the labour force either engages directly in agriculture or indirectly in agriculture-related activities. The sector has a crucial role to play in the poverty reduction and growth agenda of the government, particularly since it is estimated that most poor people in Ghana are engaged in agriculture, especially those in food crop and livestock sub-sectors.

Agriculture has consistently contributed about 36 percent of GDP since 1997. In 2003 this figure increased to 40.4 percent. Cocoa also remains one of the most important cash crops, providing livelihoods for more than a million Ghanaians and accounting for a third of foreign exchange. In 2004, cocoa receipts almost equal that of gold as the leading foreign exchange earner for the government, contributing $1 billion (or 39.2%) to total earnings in 2004.

Although Ghana has a total land area of 23.8m hectares of land resources, only 57.1 percent (13.6m hectares) is arable and therefore suitable for cultivation. Out of the 13.6 million hectares of agriculture land, only 7.2 million hectares or 30.2 percent is under cultivation as at 2004[15]. As the population grows, so too will be the demand for food, and therefore the demand for land on which to grow food. However, land available for farming decreases with increasing population, reducing the country's ability to meet its food needs. With continued high fertility (TFR of 3.6), there will be less arable land available per person for cultivation of food and cash crops in support of individual households food consumption needs as well sale of any surplus generated.

Figure 24 Arable Land per Capita (HA), 2000-2015

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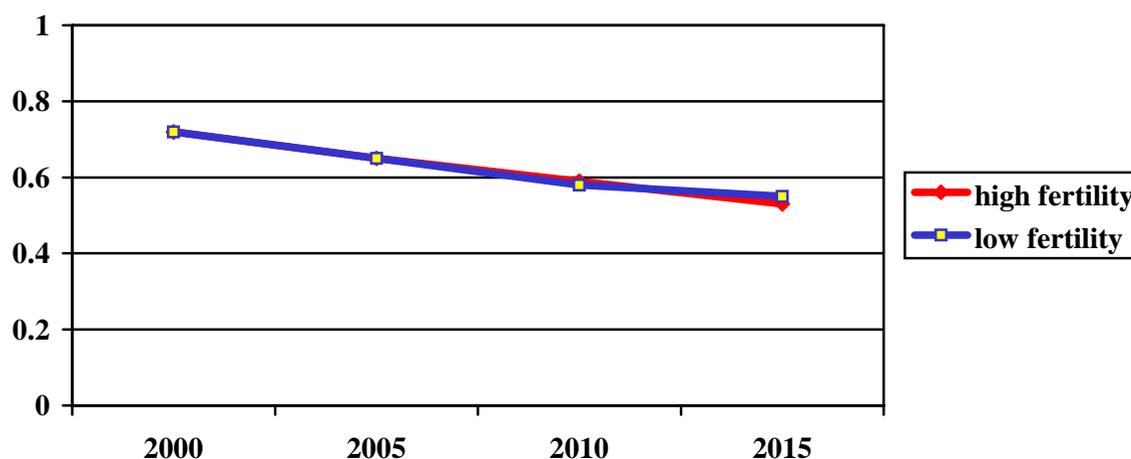
[15] MOFA. Survey Department. Agriculture in Ghana: Facts and Figures. 2004 Accra.

In 2002, with good weather, food crops production exceeded their targets thereby pushing down prices of some of the major staple foods including maize and cassava. This positive trend suffered a set back in 2004 relative to 2002 and 2003 due to bad weather and a drop in yield. In addition to population growth, food production shortfalls can be further attributed to the low investment in agriculture and an emphasis on cash crop production – cocoa in support of national economy to the neglect of the larger traditional food crop farming sector. If these and the many other challenges facing the agriculture sector are not fully addressed, it will be difficult to increase per capita food production. The general land use pattern is described in the pie-chart below.

Figure 25 General Land Use Pattern in Ghana
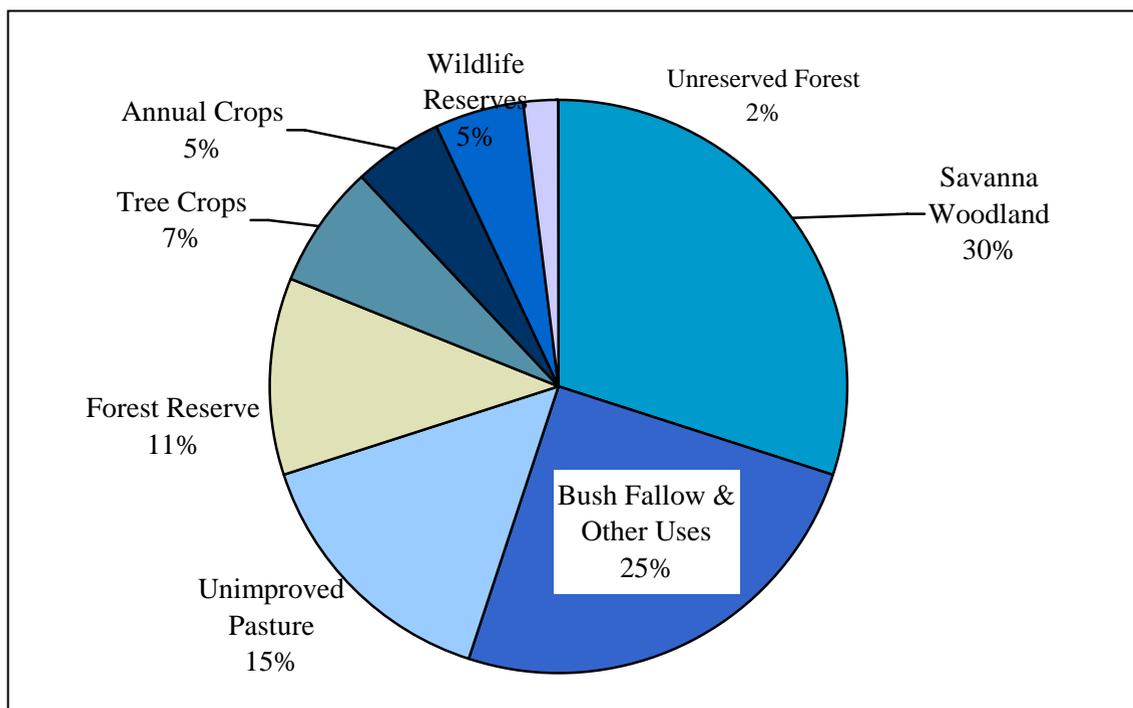
Source: PIP: Ghana RAPID 2000.

4.6 URBANIZATION

Ghana, which was less urbanized in the 1960s to early 1980s, is now increasingly becoming urbanized. According to the recent 2000 Population census, 44 percent of Ghana's population lives in urban areas, i.e., settlements with 5,000 or more people. This, more than ever, is a reflection of the obvious effect of rapid population growth, which is manifested in the increasingly crowded conditions found in Accra, Kumasi and other major cities in Ghana.

Urbanization, which is the increasing concentration of people in towns and cities occur in two ways: i) as a result of an increase in the number of urban centres and ii) as a result of

an increase in the size of the individual urban centre. Ghana's urbanization pattern reflects both of these conditions, although the latter predominates.

Figure 26. Ten Largest Urban Centres in Ghana, 1984 – 2000
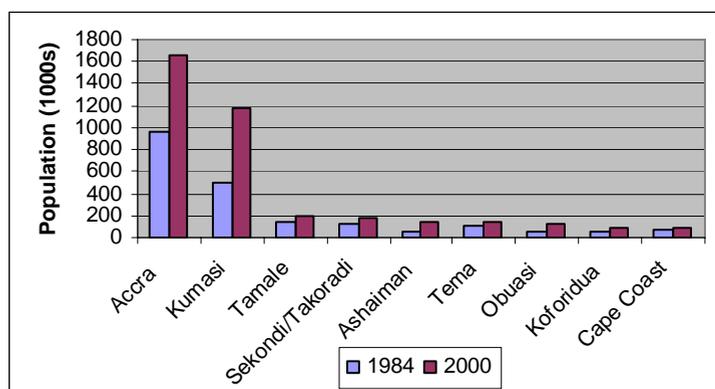
As presented in Figure 26, six out of the 10 largest urban centres in Ghana are regional capitals of Accra, Kumasi, Tamale, Sekondi/Takoradi, Koforidua and Cape Coast. The rest are the very fast growing localities of Ashiaman, Tema, and Obuasi. Also, there is a large disparity between the population of the two largest localities, namely Accra and Kumasi, and the third largest, Tamale. The point to note is that the population of Tamale has been about one-eighth that of Accra, and about one-fourth that of Kumasi since the 1970s, an indication that no deliberate policy has been made to advance the growth of smaller towns in order to take the pressure off the much bigger cities of Accra and Kumasi[16]. This pattern of urbanization is therefore more the result of migration than natural increase.

For Accra specifically, the spatial growth of this major metropolis brings into sharper focus the dangers rapid urbanization poses to Ghana's socio-economic development. Commercial activities particularly in the informal sector, have become a predominant activity in Accra and the other regional capitals. As more and more migrants troop daily from the rural areas to the cities, these activities are extended from the core to the fringes and even residential neighbourhoods of the cities. For example, in 1945, Accra occupied less than 10 percent of its present size[17]. However, it has since expanded rapidly. For the inter-censal period 1984 –2000 the rate of growth of the Greater Accra Region's population was 4.4 percent and that of Accra was 3.4 percent compared to the national average of 2.7 percent. The recent 2000 census count of the population of the Greater Accra Region is 2,909,643 million and Accra alone accounts for close to two-thirds (1.6 million) of the region's population. Projection of the future growth shows the city will soon surpass the boundaries originally demarcated for it, and its population will exceed 3 million inhabitants, reaching close to 6.0 million by 2015.

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[16] Population Impact Project: Population and Development in Ghana. Nov., 1994
[17] Population Impact Project. Population and Development in Ghana. Nov. 1994

Figure 27. Projected Total Population of Greater Accra under Two Fertility Scenarios

Even as this expansion takes place, the city seems not quite able to cope with the demands being made on it by its large population. Rapid urbanization is not only putting pressure on the already severe housing shortage in Accra, but is also contributing to severe over-crowding, the spread of slums and shantytowns, and even crime. Continued rapid population growth especially in the urban areas will therefore make it very difficult to make up for the current housing shortfall of 500,000 units, as recently announced by the Minister of Works and Housing, Hon. Hackman Owusu-Agyemang[18]. The Minister clearly attributed the problem to rapid population growth and an uncontrollable rate of urbanization.

Reduced fertility would lead to smaller household sizes, (currently put at 4.6 person per urban household), less crowding, reduced demand for new housing and less internal migration.

4.7 ENVIRONMENT

There are varied opinions on the relationship between population growth the environment and poverty. There is a fair degree of consensus however, that rapid population growth can lead to degraded environment. . Large population numbers have many implications on the environment. For example, the larger the population, especially in rural subsistence agricultural settings, the more intensive is the subsistence exploitation by poor people of the natural resources base to satisfy basic needs for survival and sustenance (food, water, energy and shelter). Large numbers of poor people therefore put pressure on the environment because their subsistence needs often require direct use of natural resources. Environmental destruction in rural areas tend to have a greater impact on income earning potential because the problems are related to the damage or destruction of the natural resources that should provide sustainable livelihoods.

In urban areas, the impact of urban population growth on the environment has been one of the most striking developments in Ghana. As already noted, the greatest concentration of people is in the Accra Metropolitan Area. On current trends, Ghana will experience serious difficulties in trying to cope with the needs of the growing city in relation to its total resources. The problem is not confined only to Accra. Sanitation in Ghana's large towns and cities has worsened over time. As the urban population grows, the volume of waste water from all households exceeds the infiltration capacity of the soils. While existing drains are deteriorating due to their small size in relation to the volume of debris they are expected to carry, a better network of modern storm drainage systems will be required to combat the perennial flooding that occurs whenever it rains.

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[18] Daily Graphic Newspaper. November 16/05

Also, in many parts of Accra and other urban centers without sewers, especially the poor neighborhoods, effluent runs through the open gutters. Linked to this is the increase in vehicular emissions and the long traffic congestions that are characteristics of Accra and Kumasi. Emission of smoke from vehicles during such traffic gridlocks, contributes subsequently to the deterioration of air quality.

The Forest Cover in Ghana has dwindled from 8.2 Million Hectares at Independence in 1957 to Between 1.5 and 1.8 Million Hectares as of 2002

Source: Prof. Kasim Kassanga, Minister of Land and Forestry, Daily Graphic, December 27, 2002

Urban Environmental Health

⇒ Only 41.5% of households in Ghana have a toilet facility in/or around house
⇒ Few houses provide adequate disposal of solid and liquid waste
⇒ 36.3% of households in Accra bury their waste
⇒ A lot more, 63.7% dump waste at public dump sites or elsewhere at their convenience (open gutters, streams, or undeveloped plots)

The impact of Poor Environmental Health Situation on Public Health

The public health consequences from the above are as follows:

⇒ Perennial flooding
⇒ Poor water quality and inadequate sanitation associated with increased incidence of diarrhoeal diseases, cholera and other bacterial pathogens
⇒ More worrying aspect is that these diseases reoccurs eg. Cholera and Typhoid in Accra
⇒ Children affected most – suffer from elevated mortality and other health risk
⇒ Health hazards including Malaria – the principal cause of death in Ghana
⇒ Malaria is environmentally borne
⇒ Malaria is heightened by over-crowding, poor drainage and poor sanitation in urban environments
⇒ Poor environment affects health in long-term by reducing in-take of nutrients and this leads to stunted growth, and causes wasting in children

5.0   MANAGING POPULATION GROWTH

5.1 Introduction

There have been key milestones signifying important political commitment to the provision of family planning/reproductive health services in Ghana over the last 30 years. As is now well known, Ghana adopted an explicit and comprehensive population policy in 1969, the third country to do so in sub-Saharan Africa. This was after Mauritius had done so in 1958, and then followed by Kenya in 1965. Titled, *'Population Planning for National Progress and Prosperity: Ghana Population Policy,* the document affirmed the Government commitment to adopt and implement appropriate strategies and programmes to manage population resources prudently and curb population growth**.** The policy was further designed to improve standards of living and quality of life, promote maternal and child health services, and address the issue of population distribution among several others. To give effect to the policy, Government established the Ghana National Family Planning Programme (GNFPP) in 1970.

> *"The population of Ghana is the nation's most valuable resource. It is both the instrument and the objective of national development. The protection and enhancement of its welfare is the Government's first responsibility. When that welfare is threatened, the Government must act."*

> *GHANA POPULATION POLICY, 1969*

In 1986, sixteen years after the establishment of the GNFPP, it became evident that the programme had only partially succeeded in propagating the idea and knowledge of family planning in the country, mostly in the urban areas. The 1980 Ghana Fertility Survey however indicated that the achievements of the programme with respect to the practice of family planning were minimal. TFR was still high (6.4 children per woman) and the population was still growing at 3.0 percent per annum. The need for a critical examination of the overall population policy therefore became apparent.

As a consequence, the 1969 Population Policy was revised, in 1994, again clearly reaffirming the key goals and challenges addressed in 1969, but also taking cognizance of new and emerging population and development concerns as later reflected in the internationally acclaimed ICPD program of action (POA) adopted in Cairo in 1994 (see Box 4).

Box 4. Goals and Objectives of the Revised 1994 Population Policy

Ghana's revised population policy outlines a set of 14 specific goals. The foundation of each of these goals is to ensure that the country achieves and maintains a level of population growth which is consistent with national development objectives. The impetus for the policy is to enhance the quality of life of the people of Ghana – women, men, children, adolescents, and the aged.

In pursuit of these goals, the population policy also has a number of objectives:

- To ensure that population issues are integrated into all aspects of development planning and implementation process.

- To reduce the high level of fertility through the provision of affordable and high quality family planning/reproductive health services through out the country.

- To develop special programmes which focus on and cater for the reproductive and sexual health needs of adolescents, including providing them with adequate education about their reproductive health.

- To reduce the high levels of morbidity and mortality, especially maternal and infant mortality, and ensure a better health care system for all.

- To ensure that particular attention is focused on the control of STIs and HIV and AIDS.

- To institute and support programmes which cater for the special needs of the aged in society.

- To enhance women's rights and status within the society and ensure their active participation in all aspects of development.

- To adopt measures to influence the volume and patterns of migration and to promote a more rational distribution of population and development between urban and rural areas and between zones and regions of the country.

- To institute and support policies and programmes to protect and conserve the environment and the nation's natural resources while, at the same time, ensuring that these resources enhance the quality of life.

The policy also outlines key targets to provide a basis for assessing, monitoring and evaluating the overall success of specific programmes covering fertility and contraceptive prevalence, population growth rate, infant mortality, maternal mortality, gender, spatial distribution among others. These are:-

- To reduce the total fertility rate (TFR) from 5.5 births per woman to 5.0 by the year 2000, and then 3.0 by the year 2020.

- To achieve a contraceptive prevalence rate (CPR) of 15 percent for modern family planning methods by the year 2000, and 50 percent by the year 2020.

- To reduce the annual population growth rate of about 3.0 per cent to 1.5 percent by the year 2020.

- To reduce infant mortality rate (IMR) from the level of 77 deaths per 1,000 live births to 24 by the year 2020.

- To reduce the maternal mortality ratio from its current level of about 2020 maternal deaths per 100,000 live births to 55 by the year 2020.

5.2 Implementation Strategies to Manage Population Growth: A Multi-Sectoral Effort

The revised 1994 Population Policy indeed recognizes that managing population growth to improve the quality of life of the people of Ghana requires integrated and well coordinated multi-sectoral strategies and interventions. Towards this end, the policy outlines a wide range of implementation strategies in order to achieve the specified objectives and targets. The establishment of the multi-sectoral National Population Council has helped to ensure that the goals and objectives are translated into effective programmes at national, regional and district levels.

To reflect its multi-sectoral character, membership of the National Population Council draws on various experts from prominent citizens and organizations within Ghana with demonstrable commitment to population issues, including representatives from the Ministries of Finance and Economic Planning, Health and Ghana Health Service, Ghana Statistical Service, National Development Planning Commission, National Council on Women and Development, faith-based groups, NGOs, Trade Union Congress, Ghana Medical Association and others.

> **Ghana's Growth Rate and the GPRS**
>
> *With the current annual population growth rate of 2.7%, a GDP growth rate of at least 6 to 7% is required to ensure a meaningful transfer of the economic gains into the well-being of the ordinary citizen.*
>
> *State of Ghana Population Report, 2003*

The Council serves as the primary body responsible for making population-related policy recommendations to the government and carrying out its work. The council is aided by a Secretariat – the National Population Council Secretariat (NPCS), whose Executive Director, serves as Member/Secretary to the Council. The NPCS provides technical and administrative support for the Council's activities.

5.3   Achievements

Against this positive policy environment, Ghana in the recent past has made significant progress in reducing its fertility. Between 1988 and 2003 there was a two-child drop in fertility. With a total fertility rate (TFR) of 4.4, Ghana's fertility rate is one of the lowest in sub-Saharan Africa. Since 1988 current use of contraception among currently married women has doubled (to 25.2 percent) and use of modern methods has increased four-fold (to 18.7 percent). The country is well on the way to meeting the goals set forth in the National Population Policy of 1994: to reduce the total fertility rate to 5.0 by 2000, 4.0 by 2010, and 3.0 by 2020; and to increase modern contraceptive prevalence rate to 15 percent by 2000, 28 percent by 2010, and 50 percent by 2020.

There are challenges, nonetheless. For example, although the TFR has declined and contraceptive prevalence has increased, unmet need remains high and women continue to have more children than they desire.

5.4   The Challenge Ahead

As already mentioned, Ghana's efforts at managing its population to ensure improved quality of life for the citizens, have seen re-invigorated actions aimed at reducing the rate of population growth through improving access to reproductive health services. Despite these, the recent analysis presented in this report shows that key challenges still have to be overcome if Ghana is to maintain the momentum generated in recent years, and even accelerate actions on several fronts.

There are admittedly some impressive policies in place, but as is now well known, there is a gap between what is on paper and what is happening in practice due to inadequate grassroots involvement, and the lack of a clear strategic plan for implementation. It has been acknowledged that *advocacy* has played a key role in raising the profile of family planning, and will be important in coming years in ensuring that family planning remains a priority in various aspects of health sector reform and in ensuring the achievement of the GRPS II and MDG targets.

To accelerate actions therefore, the following strategies have been recommended:

FP/RH and Maternal Health

❑ Review and strengthen management and coordination of FP programmes.

❑ Review and re-formulate specific guidelines to improve FP service delivery.

❑ Revise the curricula for pre-service training of FP service providers including medical officers and interns and improve skills and attitudes of providers.

❑ Develop comprehensive strategy for improving access, quality and utilization of FP services.

❑ Strengthen logistics system to ensure universal availability of wide range of commodities, while focusing on the preferences of the clients.

❑ Develop benchmarks and achievement targets for service delivery; develop appropriate strategies and guidelines for achieving them.

❑ Establish mechanisms for participation, cooperation and collaboration of major stakeholders including donors in the design, financing and implementation of FP/RH programmes.

❑ Improve messaging, making them more responsive to the fears and concerns of target groups and communities, and in so doing pay special attention to needs of men, children and adolescents.

❑ The need to re-focus BCC messages.

- Ensuring consistency in family planning messages - messages to promote family planning in Ghana should relate to the Millennium Development Goals as well as the PoA of the ICPD and should emphasize the health of women and children, education, and HIV/AIDS.

- The need to target reduction of high unmet need for FP particularly among young couples and hard to reach communities.

- Inclusion of contraceptives in the "essential drugs list" and under the National Health Insurance Scheme (NHIS).

- Accelerate implementation of safe motherhood programmes

- Assess implementation of NHIS to enable poor especially women and children to access these services

Population, Poverty and Pursuing Economic Growth

- Review economic policies to prioritize education and health

- Promote programmes that emphasize self-reliance for the formation of indigenous capital and wealth creation

- Manage the 'brain drain' particularly in the health and education sectors to ensure that Ghana benefits from its trained manpower.

- Advocate for increased investment in neglected areas of population, FP/RH and maternal health research and data utilization including mobilization for resources for census 2010.

6.0 CONCLUSION

Ghana has begun experiencing a decline in its overall level of fertility over the past 15 years. During this period, the total fertility rate (TFR) declined for women age 15-19 and those aged 20-24 by as much as 41 percent and 32 percent respectively. This decline has, however, not been uniform among all women of reproductive age. For those women aged 25-29, the decline in fertility experienced in the mid-eighties and nineties has stalled in the last three years, despite a continuing high level of unmet need for family planning and its impact on the individual and on society. In this report, the population of Ghana is projected to increase from 18.9 million as at 2000 to 26.6 million by 2015 using TFR of 3.6 children or 24.9 million with a reduced TFR of 3.0 children. The number of women of reproductive age is similarly projected to increase from 4.52 million in 2000 to 6.67 million by 2015.

This represents a tremendous challenge to the government of Ghana in providing the needed reproductive health services to women, men and adolescents who have expressed the desire to use family planning. In addition to this, higher population numbers will also make it extremely difficult for the government to meet the MDG targets as the analysis in this briefing booklet has shown. This is seen in both the continued rapid growth in expenditures that will be required to create the needed jobs, build additional classroom blocks, expand health and maternal health services to an even larger segment of the population in order to avert high maternal deaths etc.

Helping Ghanaians to achieve their desired fertility would go a long way to improving the health and saving the lives of women and infants, and reduce the unintended fertility that fuels the rate of population growth. It is therefore imperative that all stakeholders in population management and the provision of reproductive health services address these issues, consider carefully the full range of policy and programme options and implement changes needed to meet these challenges.