GHANA POPULATION STABILISATION REPORT

NATIONAL POPULATION COUNCIL

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ACKNOWLEDGENTS

Table of Contents

LIST OF TABLES AND FIGURES

CHAPTER ONE: GENERAL INTRODUTION

1.0   Introduction

Ghana is situated on the West Coast of Africa, off the Gulf of Guinea. It occupies a land area of 238,589 square kilometres and is bordered on the west by Cote d'Ivoire, east by Togo and the north by Burkina Faso. The country consists of ten administrative regions, subdivided into 170 districts to ensure efficient and effective administration at the local levels. Ghana's economy is mainly agricultural with crops produced for both local consumption and exports. Minerals and timber also contribute to the country's earnings. In 2009, Ghana attained lower middle-income status and in 2010, became an oil producing country. Currently, the country is said to have one of the fastest growing economies in the world, however, the continuous rapid population growth is threatening the economic progress achieved and has implications for the development of the country.

As in many developing countries, Ghana's population has increased rapidly over the years from 6.7 million in 1960, 18.9 million in 2000 to 24.2 million in 2010 with population growth rates averaging from f 2.4 - 2.7 percent. With a current population growth rate of 2.4 percent, the population is expected to double in 29 years. . The age structure of the population reflects a youthful population with about 40 percent of the population under 15 years of age. As a lower middle-income country, Ghana is experiencing a demographic transition with both fertility and mortality levels declining. However with a youthful population there is an in-built momentum for further growth despite the decline in fertility. This is reflected in the preliminary results of the 2010 Population and Housing Census which show that overall, the population of Ghana increased by 28 percent with all regions of the country experiencing growth. Ghana's population is rapidly urbanizing with close to 50 percent of the population living in urban areas with urban primacy being a key feature. The determination of the Government of Ghana to effectively manage the population for development is reflected in its commitment to global and regional agreements and conventions on population and development, including the International Conference on Population and Development (ICPD), the Millennium Development Goals (MDGs), Beijing Platform for Action, the World Summit on Sustainable Development and the NEPAD. Furthermore the Article 37, Clause 4 of the 1992 Constitution of Ghana enjoins

Government to maintain a policy that is consistent with the aspirations and development needs of the country. All these have found expression in the national development policy-frameworks of the country. Currently, the National Medium Term Development Policy Framework, the Ghana Shared Growth and Development Agenda (GSGDA1, 2010-2013) which constitutes the national development blue-print of the country and makes provision for effective population management.

The 1994 revised National Population Policy provides a policy framework to guide the development, implementation, monitoring and evaluation of several reproductive health and population related policies, plans and programmes in the country. . . Ghana first adopted a Population Policy in 1969 and was the third African country to do so. The policy was later revised in 1994 to incorporate new and emerging issues such as HIV/AIDS, the environment and gender.

The Ghana Population Stabilization report provides a situation analysis of the implementation of population and development policies and programmes in Ghana, its achievements challenges and makes recommendations to inform future interventions to reduce fertility and population growth. Specific objectives of the report are:

- Undertake a situation analysis of Ghana's population
- Examine national development policy frameworks including the current Ghana Shared Growth and Development Agenda, 2010-2013 to ascertain the integration of population variables into development planning
- Review the linkage between demographic factors and key reproductive health and population and development issues, polices and programmes
- Determine future prospects and projections
- Provide recommendations and the way forward

It is worth noting the significance of the period that this report is being prepared which is just after the 2010 round Population and Housing Census in Ghana and the attainment of a global population size of 7 billion in October 2011 and the implications of Ghana's increasing

population to this global phenomena and the centrality of population issues in national development. This report is a therefore clarion call for accelerated action by all stakeholders to ensure that the population is commensurate with the aspirations of the people. This report is expected to contribute to strengthening policy and programme interventions to improve the quality of life of the people of Ghana.

1.2 Methodology

The preparation of the report was undertaken by staff of the National Population Council, Ghana. The report is largely descriptive and uses secondary data from censuses, surveys, and other national reports.

1.3 Organization of Report

The report is organized into six chapters. It begins with an introductory chapter which provides a general introduction and background to the report, Chapter Two discusses the Population Situation Analysis, trends in population growth and size, socio-economic characteristics as well as key reproductive health and population and development issues in the Country. Chapter three examines the integration of population into national development frameworks–and c1hapter four reviews reproductive health and population policies and programmes, achievements and challenges. Chapter five focuses on future prospects and projections and concludes with chapter six providing some recommendations, the way forward.

CHAPTER 2: POPULATION SITUATION ANALYSIS

2.0   Introduction

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 (GDHS, 2008)The rapid growth of the population has created a youthful age cohort whose numbers are still expanding and which has an in-built momentum for rapid population growth. This has profound implications for development and quality of life for the people of the country. As in countries all over the world, Ghana's demographic processes play a vital role in her development. Changes population growth, age structure, composition of the population have direct and indirect impact on national development and poverty reduction, as well as the general welfare and well-being of the population.

This chapter presents the population situation as it pertains in Ghana including trends in growth and size of the population, age-sex structure and other key development issues. This chapter provides the basis for discussions in the subsequent chapters.

2.1   History of Ghana's Population

Ghana's first post-independence population census in 1961 counted about 6.7 million inhabitants. By 1970 the national census registered 8.5 million people, about 27 percent increase, while the census in 1984 recorded a figure of 12.3 million, almost double the 1960 figure. The population of Ghana was 18.9 million in 2000 and increased to 24.2 million in 2010 with an inter-censal growth rate of 2.4 percent. With such a high population growth rate, the population is expected to double in 29 years.

Between 1965 and 1989, 45 percent of the nation's total female population was of childbearing age. The crude birth rate of 47 per 1,000 population recorded for 1965 dropped to 44 per 1,000 population in 1992. In the same period, fertility averaged from about seven children per female and was expected to fall to five children per a female by the year 2000. Crude death rate of 18 per 1,000 in 1965 fell to 13 per 1,000 in 1992. Likewise, infant mortality rate which fell from 120 per 1,000 live births 1965 to 86 per 1,000 live births in 1992.

The population structure of Ghana, typical of sub-Saharan Africa, is predominantly youthful. Since 1960, the population described as young people in Ghana (10 - 24 years) has increased steadily both in terms of proportion and in absolute numbers. This situation is the direct consequence of high fertility and declining mortality of past years. Due to the demographic momentum, these increases in population are expected to continue for at least the next decade in spite of the apparent decline in fertility

2.2   Population Trends

The provisional results of the 2010 Population and Housing Census indicate that the population of Ghana is 24.2 million with a growth rate of 2.4 percent per annum between 2000-2010. It is estimated that about 40 percent of the population was under the age of 15 years in 2010 while elderly persons aged 65 years and above was estimated to be 4.5 percent of the population with women forming 51.3 **percent** of the population. According to the 2008 Ghana Demographic and Health Survey (GDHS), total fertility rate is 4.0 children per woman, coupled with a low contraceptive usage of 17 percent for modern methods. With low educational attainment levels among women in particular, there are indications that Ghana has the potential for further high population growth.

2.2.1 Population Age-Sex Structure

A major demographic consequence of high fertility is that the population tends to be youthful or young. The proportion of the population less than 15 years in 2000 was 41.3 per cent, while those aged 65 years and above was only 5.3 per cent (2000 Population and Housing Census).

Figure 1: Age-Sex Structure of Population (Population Pyramid)
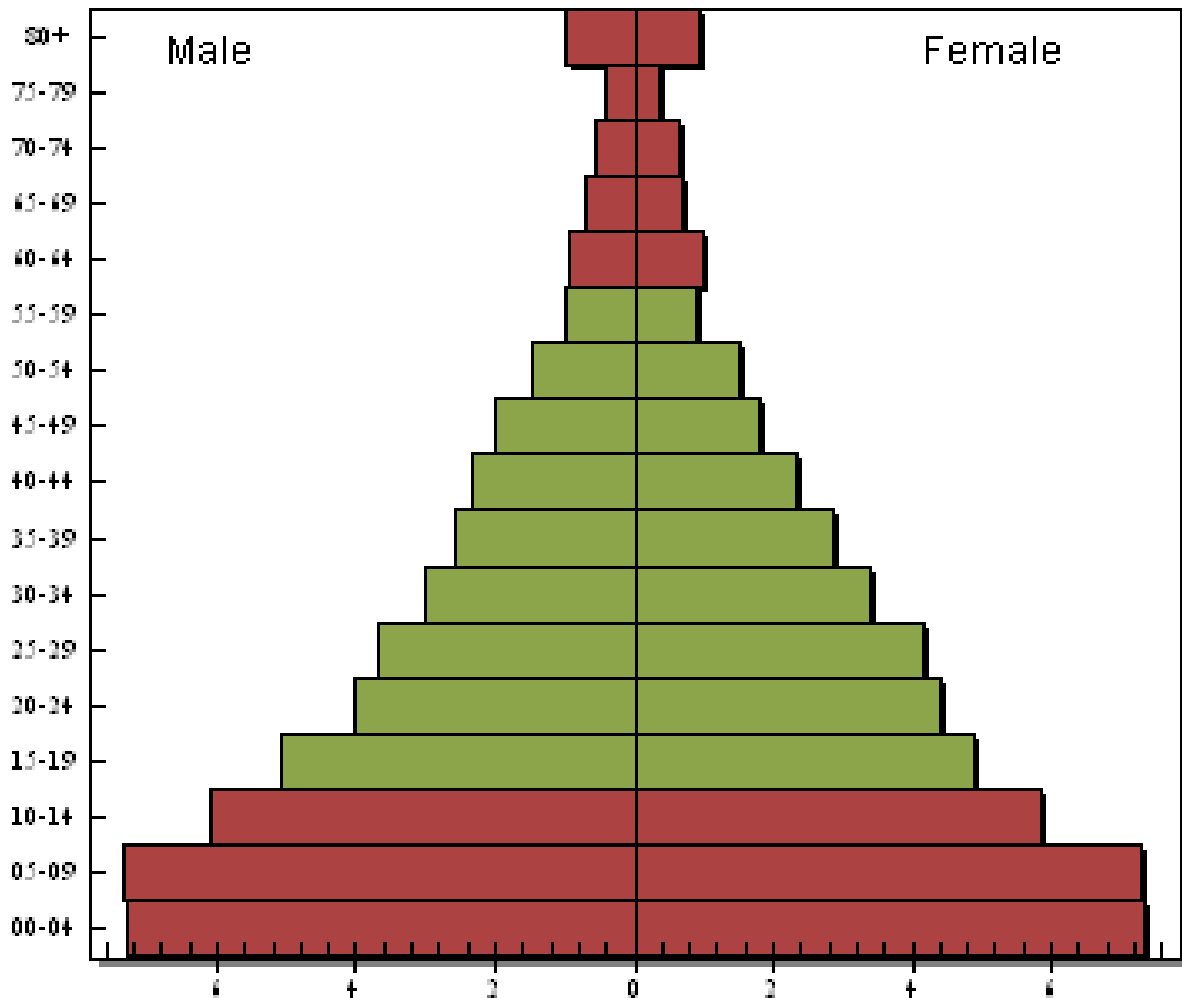
Source: Ghana Population and Housing Census, 2000

The population pyramid of Ghana in Figure 1 has a broad base which clearly indicates the heavy concentration of Ghana's population in the younger ages (below 15 years). The rapid growth and youthful structure of Ghana's population pose special challenges. It is also an indication of a high dependency ratio which usually leads to low savings and poor living standards.

2.2.3   Fertility Trends

Available evidence from the various Ghana Demographic and Health Surveys (GDHS) indicate clearly that the fertility behavior of Ghana's population is changing . Total Fertility Rate (TFR) has declined from 6.4 in 1988 to 4.4 in 2003 and 4.0 in 2008, a decline of 2.4 children per

woman within 20 years. Urban fertility between 2003 and 2008 was 3.1 compared to 5.6 for the rural area in 2003 and 4.9 in 2008. Furthermore, fertility among women with higher education (secondary school and above) was 2.5 compared to an average of 6.0 children for those with no education in 2008. This depicts a country that is moving from the first stage of the demographic transition where both birth and death rates are high to the second stage (NPC/ TPP, 2006). Despite the declines in fertility recorded, various socio-cultural practices and beliefs tend to sustain the high levels of fertility. Further declines in TFR can be achieved if the right programmatic interventions are put in place.

2.3   Mortality

2.3.1 Maternal Mortality

Death rates in Ghana have been steadily declining over the years as a result of a combination of factors including improvements in health conditions, increasing education and modernisation. Life expectancy is estimated at 59 years (57 years for males and 61 for females). Maternal mortality has been high at a national average of 451 deaths per 100,000 live births (Ghana Maternal Health Survey, 2007) although maternal mortality rate of more than 700 has been recorded in studies carried out in some districts, particularly in Northern Ghana in the early 1980. According to revised UN estimates, Ghana has a maternal mortality rate of 350 per 100,000 live births. Even though maternal mortality has recorded gradual decline, the slow pace of decline not adequate enough for Ghana to achieve the Millennium Development Goal 5 of reducing maternal mortality by 75 percent by 2015. To achieve this Ghana's maternal mortality should be reduced to 185 or less by 2015.

Figure 2: Trends in Maternal Mortality Ratio in Ghana
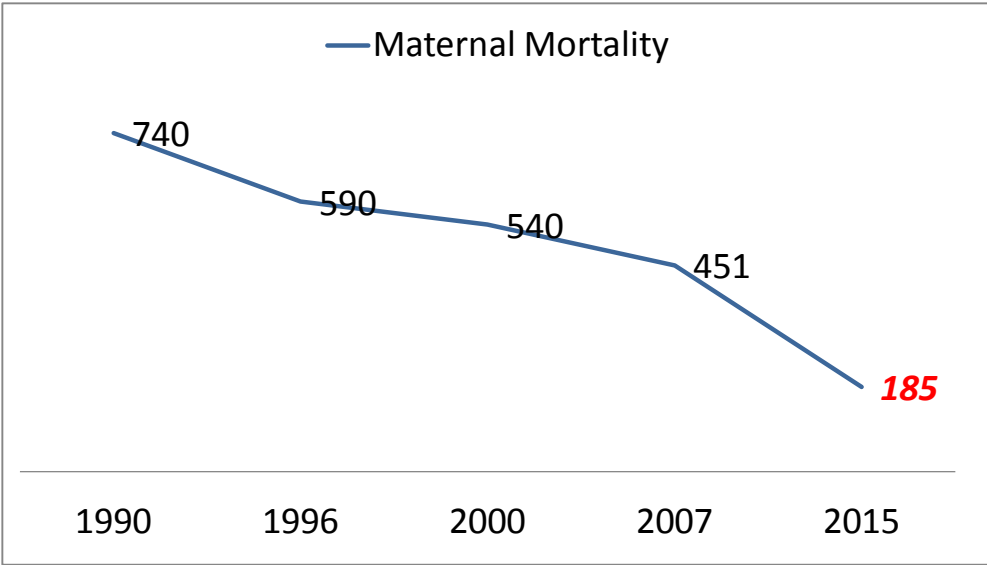
Source: GHS, 2010

2.3.2 Infant & Child Mortality

Infant mortality declined from 77 per 1000 live births in 1988 to 66 in 1993 and 57 in 1998 but rose to 64 in 2003. Currently, infant mortality in Ghana is 50 deaths per 1,000 live births and under-five mortality is 80 deaths. Under-five mortality has shown a similar trend, declining from 155 in 1988 to 111 in 1993, 108 in 1993, and then rising to 111 in 2003 with slightly higher rates for males than for females. This means that 1 in every 20 Ghanaian child dies before reaching age one, and 1 in every 13 dies before his/her fifth birthday. Even though the country has experienced declines in infant and child mortality, the current mortality rates are still considered high.

There are significant regional variations in under-five child mortalities in the country, ranging from as low as 50/1000 in Greater Accra Region to as high as 142/1000 in the Upper West Region.

Mortality levels in rural areas have consistently been higher than the urban areas. In the ten year period before the survey, infant mortality in rural areas was 56 deaths per 1000 live births, compared with 46 deaths per 1000 live births in urban areas. The under-five mortality rate during the same period was 90 deaths per 1,000 live births in rural areas and 75 deaths per 1000 live births in urban areas.

Figure 3: Trends in Neonatal, Infant, and Under-5 Mortality Rates

Trends in Neonatal, Infant, and Under-5 Mortality Rates

— under 5 Mortality   — Infant Mortality   — Neonatal Mortality

	1988	1993	1998	2003	2008
under 5 Mortality	155	119	108	111	80
Infant Mortality	77	66	57	64	50
Neonatal Mortality	41		30	43	30
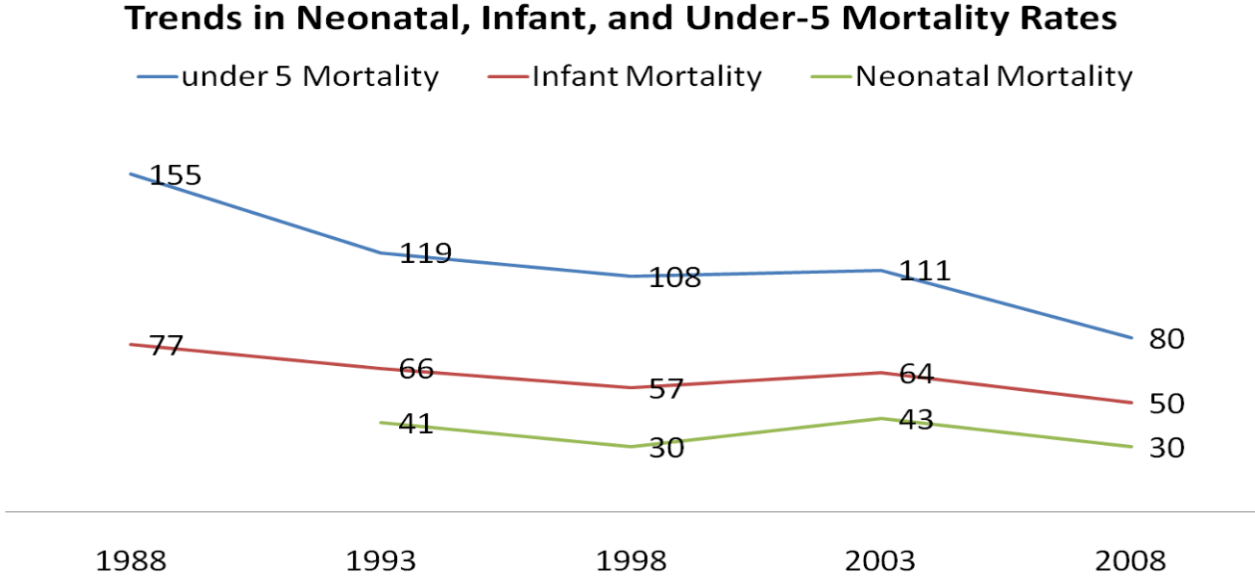
Source: GHS, 2010

2.4 The Dependent Population

In a fast growing population, the proportion of children increases faster than any other age group. In Ghana this proportion has been between 47 percent and 48 percent since the early 1950s. The economically productive age group (15 – 64 years), has been under 50 percent of the total population and those over 64 years old, about 3.0 percent. This means there is roughly one dependent person (under 15 or over 64 years old) for every economically active adult compared to about 2 adults per dependent in more developed countries. The need to provide for economically dependent persons puts pressure on the resources of the government and individual

households. The ability to care for the dependent population depends on the structure and stability of the economy and the income levels and organizational abilities of the population.

2.5   Education (Literacy Levels)

The Government of Ghana places high priority on educating children and preparing them to meet the needs of a growing economy. Towards this end, the 1992 Constitution provides that basic education should be free, compulsory and available to all. This led to the launch 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 Population Policy with regard to education aims at increasing the proportion of females completing high school. Thus the policy has as a target to increase the proportion of 15-19 year olds with secondary education and higher by 50 per cent by 2005 and up to 80 percent by 2020. is in line with national development priorities. The Government of Ghana has given priority to girl-child by developing and implementing policies and special programmes to provide equal opportunities to girls. The establishment of a Girl-child Unit at the Ministry of Education for example aims at bridging the gap in access to education. The GPR at the national level increased from 91 percent in 2002/2003 to 96 percent in 2007/2008, this is an indication of rapid increase in female enrolment into schools. The data shows an improvement on but a lot more needs to be done particularly in the retention of girls in school.

The literacy rate for women in Ghana is 52 percent compared to 63 percent for men in 2010. The low level of literacy among females has consequences for fertility behaviour, mortality and development. Illiteracy among females is associated with high fertility and maternal mortality and low level of empowerment.

2.6   General Health Care Services/Systems

There are serious manpower constraints in the health sector. There are 2,306 doctors in the country with a doctor population ratio of 1: 9,455. There are wide regional variations and mal-distribution with about 70 percent based in the most urbanized regions of the country, (The

Health Sector in Ghana, (2009), Facts and Figures). The country has a nurse population ratio of 1:1,800 and a midwives population ratio of 1: 7,600. This presents a serious challenge for safe motherhood services as the number of service providers, especially midwives are woefully inadequate to deal with the number of expected pregnancies which stands at 4 percent of the population.

2.7   Rural/Urban Patterns (Urbanization trends)

The rapid growth of the urban population since 1970 has gradually changed the pattern of the spatial distribution of the total population of Ghana. This pattern is a result of the largely urban-biased socio-economic policies and programmes thus   widening gap in earnings and opportunities between urban and rural areas. Cities and towns have increasingly become the economic, industrial, commercial, technological and social centres of the modern economy. These developments have affected young people, especially those pursuing post-basic education or are transiting into the world of work. They are compelled to migrate from rural to the urban areas to seek better job and other opportunities.

The urban population in Ghana increased from 29 percent in 1970 to 32 percent in 1984 and 44 percent. Average annual growth rates between 1970 and 2000 were higher for urban areas (4.0 percent) than for rural areas (1.9 percent). The growth in urban areas is primarily through natural increase. Projections indicate that by 2025 percent 63 percent of the total population of Ghana will live in urban areas by 2010 and 2025 respectively (GSS: 2005).

2.8   Poverty Levels

According to the 2010 MDG report for Ghana, is on track to achieving MDG 1 - of halving the proportion of the population in extreme poverty. The overall poverty rate has declined substantially over the past two decades from 51.7 percent in 1991/92 to 28.5 percent in 2005/6, indicating that the target could be achieved well ahead of the 2015 target of 26 percent. Similarly, the proportion of the population living below the extreme poverty line declined from 36.5 percent to 18.2 percent over the same period against the 2015 target of 19 percent. Real GDP growth averaged 4.3 percent during the period 1998-2002 and since then rose to exceeded 5

percent to a high of 7.3 percent in 2008. Available data indicate that per capita GDP increased from US$402.32 to US$712.25 between 2003 and 2008.

The decline in poverty is attributed to significant growth in the economy over the past decades accompanied by sound social and economic policies on poverty reduction as spelled out in the GPRS II and the GSGDA, 2010-2013. These include the capitation grant; school feeding programme; Livelihood Empowerment against Poverty Programme (LEAP); free school uniforms, National Health Insurance Scheme; Microfinance and Small Loan Centre (MASLOC) and Gender Responsive Skills Committee Development Project; Savannah Accelerated Development Initiative . These programmes are intended to provide skills acquisition and to reduce the levels of food insecurity, malnutrition and poverty in targeted communities. The GSGDA 2010-2013 is underpinned by the fact that Ghana has discovered crude oil and natural gas in commercial quantities. The expectation of these natural resources, which commenced in the last quarter of 2010, will significantly change the trajectory of economic growth and the level of per capita income. As a result of rebasing the economy, in 2010, Ghana attained lower level middle income status without the concomitant structural changes that are typically characteristic of middle-income countries. Together with cocoa and gold, oil and gas would be the main drivers of economic growth. The proceeds from oil and gas would be channelled in catalyzing the growth potential of the other sectors, especially agriculture, human development, water and sanitation and infrastructure, particularly transportation, housing, ICT and energy to enhance Ghana's socio-economic development.

2.9 Cross Cutting Issues

2.9.1 HIV/AIDS Prevalence

The number of persons living with HIV and AIDS in Ghana is estimated to be 267,069 comprising 154,612 females, 86,791 males, and 25,666 children. 20,313 people are reported to die yearly from AIDS. A total of 25,531 (14,216 females) new infections were estimated to have occurred in 2009 (National AIDS/STI Control Programme, 2009).

Figure 4: Trends in HIV Prevalence

Median HIV Prevalence 2000 - 2009, with Linear Trend
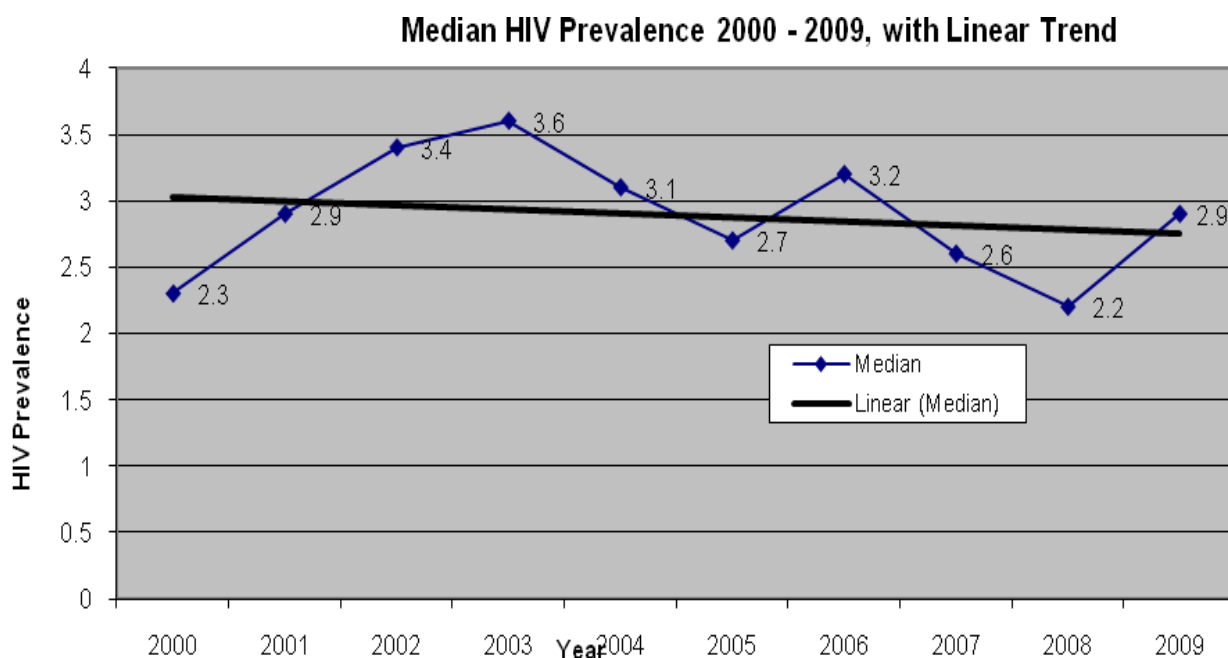
According to the 2009 HIV Sentinel Survey Report, adult HIV prevalence increased slightly from 1.7 percent to 1.9 percent with the median ANC prevalence stepping up to 2.9 percent. Prevalence among young persons, aged 15 to 24 years which is used as a proxy for new infections was 2.1 percent from the previous year of 1.9 percent. HIV and AIDS prevalence also declined from 3.2 percent in 2006 to 1.7 in 2010. Reported cases in Ghana have been mainly among persons 15-49 years who constitute the economically active labour force and the most sexually active. The female-male ratio of HIV infected persons, which was 6:1 in 1987, is currently 2:1.

2.9.2 Gender

In Ghana as in many parts of the world, male members of the family are the key power holders while women's decision-making is limited to the social aspects of the family. To a large extent, the colonial system in Ghana, further excluded some of the decision making roles women played in Ghanaian society, property ownership and reinforced women's subordinate position in society. The post-independence development initiatives continued to draw from and build on existing patriarchal structures in ways that resulted in the deepening of social and gender divides. |In

Ghana, majority of women are underrepresented in politics and compared to men they have low participation in education. In terms of health, women's health needs are largely unmet. They have major responsibilities in providing for household energy, water and sanitation needs, food especially among the poor and deprived. The status of women's health is reflected in indicators such as maternal mortality and morbidity, contraception, abortion etc. The high maternal mortality and low educational levels put women in a low social and economic status which further limits their access to quality health care services including family planning.

In the agricultural sector for example, even though women are seen to be dominating in agriculture, they are disadvantaged (GSS, 2000). Women in crop farming contribute about 55 to 60 percent) of production, however they are still the poorest. Women continue to lack access to land which is seen as the initial factor of production in agriculture. Lack of access to credit facilities is also a major constraint to improvements in women's economic activities.

To address gender inequality and empowerment of women, the Government of Ghana has ratified a number of international instruments. These include the Convention on the Elimination of all forms of discrimination against women (CEDAW), Beijing Declaration and Platform for Action, AU protocol on the Rights of Women, the Solemn Declaration on Gender Equality in Africa (SDGEA), MDGs, and the African Women's Decade (AWP) among others.

The Ministry of Women and Children's Affairs (MoWAC) with the mission "to champion the cause of all women and children' has promoted the establishment of Gender Desks and Units in sector ministries in the country. In addition, the ministry has trained staff of Ministries, Departments and Agencies as well as some metropolitan, municipal and districts and selected MMDAs in gender mainstreaming, analysis and budgeting to give a gender perspective to all sectors of the economy. Indeed the current National Development Plan has incorporated gender specific indicators on sectors of the economy which will be monitored by the National Development Planning Commission (NDPC).

2.9.3 Vulnerability

The vulnerable in Ghana include women, girls, children, aged, persons with disability and people living with HIV/AIDS. Children in Ghana are confronted with several challenges and these include child poverty, child marriage, orphaned and vulnerable children, streetism, children in conflict with the law; and child slavery.

The aged constitute 5 percent of Ghana's population. There are many issues that affect the aged, these include discrimination, abuse, neglect, violence, chronic health conditions and lack of access to nutritionally safe food and clean water resulting in nutrition deficiencies; lack of public support and institutional care systems; lack of geriatric specialists in the health sector; high cost of assistive devices; and the lack of involvement in decision-making. The absence of a comprehensive policy on ageing aggravats the already difficult situation for the aged especially as the extended family which provided a major support to the aged disintegrates with modernisation.

The prevention of disability and the care of people with disabilities as productive citizens is an important aspect of the development of the nation's human resources. In recent times, disability has achieved a significant milestone with the enactment of the Disability Act and the establishment of the Disability Council . Among the issues for urgent attention are the lack of a legislative instrument and implementation plan to drive the implementation of the Act. High incidences of poverty among Persons with disability (PWDs) due to very low levels or lack of formal education; inaccessible public transport inadequate and unfriendly walk ways f, inaccessible and unfriendly environmental, water and sanitation facilities and inadequate research on disability issues among others continue to plague the disabled and those concerned with issues of the aged.

Chapter Three: Integration of Population into National Development Frameworks

3.0 Introduction

The goal of socio-economic development is the improvement of the standard living of the population and this can only be achieved if population factors are integrated in policies, which guide the government to implement activities and programmes. The NPC has the responsibility to ensure the that population issues are systematically integrated in all aspects of development planning and activity at all levels of the administrative structure. Over the years, government has developed plans and frameworks that have sought to accelerate population growth while also managing the population for sustained economic development. Several social policies including health, education, housing, agriculture and the population policy have all incorporated population factors to various degrees.

In 2001, Ghana accessed the *Heavily Indebted Poor Countries (HIPC) Initiative* as one of the measures to accelerate economic growth. A key condition for countries to qualify for debt reduction under this initiative is that a country must have developed a *Poverty Reduction Strategy Paper (PRSP)* through a broad-based participatory process. Thus in April 2002, Ghana launched the *Ghana Poverty Reduction Strategy (GPRS I)*. In 2004 a successor framework dubbed the *Growth and Poverty Reduction Strategy (GPRS II)* was adopted. The GPRS II (2006-2009) is strategically founded on 'accelerated growth as a means of wealth creation, poverty reduction and equitable development. In December 2010, Ghana launched the Medium-Term National Development Policy Framework, "Ghana Shared Growth and Development Agenda (GSGDA), 2010-2013 Volume 1. This framework seeks to address the challenges and setbacks of the immediate past. It is designed to accelerate employment creation and income generation for poverty reduction and shared growth.

The GSGDA, 2010-2013 is aimed at ensuring that the new growth poles are reinforced to accelerate poverty reduction without becoming enclaves. In pursuance of this mandate, the national policy framework has outlined the following social and economic goals: These include:

- Providing citizens with secure and sustainable jobs

- Ensuring gender equity in access to productive resources such as land, labour, technology, capital/finance and information

- Expanding access to potable water and sanitation, health, housing and education

- Embarking on an affirmative action to rectify errors of the past, particularly as they relate to discrimination against women

- Pursuing an employment-led economic growth strategy that will appropriately link agriculture to industry, particularly manufacturing

- Rehabilitating and expanding infrastructural facilities

These social and economic goals are very crucial in achieving socio-economic development in of the country. Strategies to be employed entail improved enabling environment to empower the private sector, active collaboration between the public and private sectors, including public-private partnerships and civil society organizations, active government interventions where appropriate, transparent and accountable governance and efficiency in public service delivery at all levels; and effective decentralisation for enhanced local economic development.

Population dynamics, including growth rates, age structure, fertility and mortality, migration influence every aspect of human, social and economic development. It is in this regard that the current medium-term National Development Policy Framework *Ghana Shared Growth and Development Agenda (GSGDA) 2010-2013* places emphasis on maintaining a population growth at a level capable of sustaining and supporting economic growth and social development. The framework also acknowledges that weak population management structures and processes as well as inadequate population data for planning constrain effective population management.

Since the Government of Ghana begun decentralization reforms in the late 1980s a number of policies, strategies and programmes have been developed in support of its decentralization policy. The 1992 Constitution and various legislations on decentralization articulate the principles and objectives of decentralization. District Assemblies have been established as planning authorities under the Local Government System Act of 1993 and the National Development Planning Systems Act of 1994. District Planning and Coordinating Units (DPCU)

of the District Assemblies ensure that planning is undertaken at the district level. A recent review of the level of integration of population variables into district plans indicated that the districts considered population factors to a minimal degree in their plans. Most of the plans failed to use projected figures of the population to estimate for future needs.

As part of its mandate, is working to build the capacity of District Assembly staff in the use of data for planning and in practical methodologies for integrating population concerns into district plans. With support from UNFPA, NPC contracted the Department of Planning at the Kwame Nkrumah University of Science and technology to develop a set of modules that would be used to train District Staff, including planners and budget officers on the concepts and methodologies for making population issues central to development plans. The use of the modules in training staff of DPCUs in performing their planning and coordination function is of great benefit to the country where well trained local government officers are critical to administration of a decentralized system of government.

Ghana has adopted policies and strategies which protect and promote the growth and development of people in the country, along with in-depth public education on the policies. Some of the policies include the Revised National Population Policy, 1994, National Youth Policy, Adolescent Reproductive Health Policy, National Gender and Children Policy, National HIV/AIDS and STI Policy and National Reproductive Health and Service Policy and Standards. Some of the policies have included population variables in their implementation strategies and objectives. The National Population Policy (Revised Edition, 1994) was adopted to improve the quality of life of the population. One of the goals of the policy is that measures will be taken to improve the standard of living and the quality of life of the people. Policies will be pursued to alleviate mass poverty among people and enhance the welfare of the population at large. In relation to the goals, the policy stated some objectives to ensure the achievement of the goals. Some of the objectives are that population issues are systematically integrated in all aspects of development planning and activity at all levels of the administrative structure, to educate the general population on the need to conserve the environment as well as promote environmental quality and to develop programmes aimed at the empowerment of women to increase their

participation in the modern sector, engage in income-generating activities, and enhance their economic well being generally. To an extent the goals and the objective aim to ensure the integration of population variable in to development planning. The policy seeks to ensure that efforts are made to integrate population variables in all aspects of national development planning and programmes within the context of the national decentralized policy. In order to realize the goals and objectives set by the Policy, the following implementation strategies shall be pursued, some of which are, Maternal and Child Health, Health and Welfare, Education, Empowerment of Women, Migration, Environmental Programmes, Housing Strategies, Data Collection and Analysis, Research and Monitoring and Evaluation.

A draft National Youth Policy was first published in 1999 and subsequently reviewed and adopted in 2010. It is one of the national policies developed specifically to cater to the challenges of young people in Ghana which is in line with Governments responsibility of ensuring the systematic integration of population factors into all aspects of development planning and activity as outlined in the goals and objectives of the National Population Policy (Revised Edition) of Ghana. The vision of the policy is an empowered youth contributing positively to national development. In order to realize its vision the Policy stated some objectives which are

- Empower and actively involve the youth of Ghana in productive activities for individual, community, and national development.
- Enable each Ghanaian youth develop his or her full potential and self-esteem.
- Institutionalize youth participation at all levels of the decision making process to ensure the nurturing of democratic culture.
- Enable the youth acquire, share and transfer knowledge, expertise, and experience through domestic and international networking and peer-learning.
- Inspire the youth to develop the aptitude for creativity, innovation and self-discovery in improving their quality of life.
- Inculcate in the youth a strong sense of self-reliance, patriotism, nationalism, and volunteerism.

The policy also focuses on some priority areas such as education and skills training, science, research and technology, information communication technology, gender mainstreaming, youth and employment and youth in modern agriculture. The National Youth Policy (NYP) recognizes the need to develop more strategic interventions and approaches to attract the youth particularly those in the informal sector like the agricultural sector. The policy outlines as a goal, the promotion of youth participation in agriculture through the promotion of youth in modern agriculture as a viable career opportunity for the youth and then as an economic and business option and the provision of resources for the participation of the youth in modern agriculture. In order to achieve

In response to the need for a comprehensive national policy to address all issues related to HIV/AIDS which as documented in Ghana is prevalent among persons between 15-49 years (the most product years in the Ghanaian society), a National HIV/AIDS and STI Policy document was developed and adopted by The Government of Ghana in 2004. The goals of the policy are to ensure, reduction of the risk of infection in the population, reduction and mitigation of the socio-economic, physiological and other consequences of HIV infection on the infected as well as affected persons and society as a whole and promotion of healthy life style and strong family values. Some of the strategies adopted include:

- Promoting the genuine participation of people in the national response to HIV/AIDS and STI prevention and control
- Ensuring care and support for people living with HIV/AIDS/STIs, AIDS orphans and people whose parents, guardians and other relatives are HIV positive
- Reviewing national policies in order to promote those that reduce the vulnerability to HIV/AIDS and STIs
- Strengthening the integration of HIV/AIDS education into the curriculum of formal schooling from primary school level
- Mobilizing parents, policy makers, media and religious organizations to influence public opinion and policies with regard to HIV/AIDS and STIs, and improve the quality and coverage of in-school and out-of-school programmes

The policy provides the necessary statement of commitment around which a legislative framework is to be built for an Expanded Multi-sectoral Response to reduce the further spread of HIV/AIDS and other STI's, and for the protection and support of people infected with HIV/AIDS in Ghana. The national HIV/AIDS and STI policy acknowledges that the ability to cope with the consequences of HIV/AIDS including its transmission cannot be isolated from the demographic and other factors in the country. It explains that despite Ghana's fairly low mortality and high fertility which has resulted in a fast growing population, observed increases in HIV prevalence level are likely to invariably lead to a reduction in life expectancy and a steady rise in infant mortality as exemplified in the over 20 percent rise in HIV sero-prevalence level among young adults, 15 years and older in 2000. With regard to the economy, the policy identifies the enormous consequences that the depletion of the workforce might cause in terms of loss in numbers, skills and reduction in personal productivity. For instance increase in HIV/AIDS prevalence may actually lead to a reduction in local food production and effectively threaten the food security of the entire nation. In the education sector, the targets for manpower development and training are unlikely to be met and the rate of replacement may never match attrition due to either premature or increased loss from the service. This may ultimately affect the quality of the educational system.

The Adolescent Reproductive Health Policy seeks to strengthen adolescent reproductive health services in Ghana with the adoption of a multi sectoral approach, involving appropriate institutions of government, private/civil society organization and individuals to achieve the objective of adolescent health programmes. The Policy seeks to invest in young people as a measure to assist in reducing the contribution of teenage pregnancies to overall fertility of the country, prevent RTI, including HIV/AIDS, among young adults and create a conducive and healthy environment for young people to learn about their own sexuality and that of the opposite sex. The development of the policy is to promote the rights of adolescents to sexual and reproductive health information and services in an atmosphere of friendliness. Some of the objectives outlined in the policy targeted at improving the socio economic status of adolescents include among others:

- Promote other policies that will enhance the development and implementation of adolescent sexual and reproductive health programmes
- Pursue policies and programmes that will eliminate gender-based violence and biases against the girl-child
- Improve access to education and create employment opportunities for adolescents, particularly females as well as rural and urban poor youth
- Support and strengthen training programmes for adolescents on various aspects of sexual and reproductive health

The development of the policy has extensively promoted the implementation of Adolescent Sexual Reproductive Health programmes such that adolescent health services have been integrated into the country's major health sector plan. This is to increase the level of knowledge about reproductive health among the youth. The reproductive health component has also been included in the educational curriculum from the junior high level of education to the senior high level, whiles various programmes have been developed for the out of school youth. The policy also emphasises the need to empower the youth through skills development, this also includes livelihood skills.

In Ghana women bare the largest poverty burden, suffering from preventable diseases relating to complication due to pregnancy and malnutrition. In order to promote equality, equity and empower women, the Gender and Children's Policy (2005) was adopted. The policy seeks among other things to promote the health and welfare of women and children and to mainstream gender and children's concerns. The objectives stated in the policy were mainly on the promotion of children development and survival, address issues of existing gender inequalities through policy review, legal reforms and enforcement of existing gender legislation, enable women to have equal access to and control over economically significant resources and benefits and provide a national framework from which policies are developed.

The policy objectives ensure that women and children benefit from all development programmes and plans aimed at enhancing their health and welfare. The promotion of female education with

particular focus on the girl child has lead to the increased participation of women in politics and the inclusion of women's concern to women and children. The improvement in the educational level of women leads to a reduction in fertility and the promotion of the health and well being of the family as whole. The introduction of skill training programmes and the establishment of women's development fund to provide micro credit schemes to enable women in the informal sectors to set up small business, cultivate their farms process food in order to make them financially independent so they can contribute to family income and well being.

3.2   The National Reproductive Health Service Policy & Standards

The document which was first produced in 1996 and revised in 2003 strongly indicates governments pledge to the health and well being of women, childen and adolescents. The policy covers areas in Safe Motherhood Services, Family planning, Prevention and Management of Unsafe Abortion and Post-Abrtion Care, Prevention and Management of Fertility and Harmful Practices. The strategies include integration of family life education (FLE) into school curriculum and out-of-school programmes, create awareness of the problem of gender-based violence and its implications for reproductive health and provide aid to victims of gender based violence by linking them to organizations that addresses these issues. Reproductive health is very crucial when dealing with health issues among women. This is because most women do not have control over their health especially when it comes to regulating fertility and using contraceptives, this has implications for development planning. By adopting the policy the government seeks to improve the health and well being of the population.

All these programmes would enhance the health status of the populace since it is the basic rights of all couples and individuals to decide freely and responsibly their reproductive goals and must be given information to do so. In all the policies, population variables (education, health, agriculture, employment, environment etc.) have not been left out of the document. They are part of the implementation strategies to achieve socio-economic development.

Chapter Four: Population Policies and Programmes

4.0 Introduction

Since Ghana attained her independence in 1957, a number of policies have been put in place to promote the welfare of her citizens with varying degrees of success. This chapter presents a review of some of these policies and programmes and their impact on slowing population growth and poverty reduction.

4.1 Education

Ghana has since independence made significant strides in the education system.

Article 25 (1) of the 1992 Constitution of the Republic of Ghana endorses educational rights by stating that all persons shall have the right to equal educational opportunities and facilities. In recognition of this right, the government introduced the Free Compulsory Basic Educationin 1996 to (Fexpand access to good quality education and to promote efficient teaching and learning. Section 5.5.1 of the 1994 revised population policy states that "subject to the availability of resources, free and compulsory universal basic education shall be provided. Policies and programmes that encourage girls to continue schooling up to at least the secondary school level will be vigorously pursued".

Furthermore, section 5.5.2 of the policy states hat special programmes shall be developed to improve low enrolment rate and reduce the high school drop rate through practical and technical training that will provide ample opportunities for gainful self-employment.

Formal education in Ghana begins with six years of primary education (ages 6-11), three years of junior secondary school (ages 12-14) and three years of senior secondary school (ages 15-18), concluding with the tertiary level of universities, polytechnics and other higher level institutions. The number of children of primary school-going age (6-11 years) doubled in three decades from 1.5 million in 1970 to 3.1 million in 2000. (see Table 1). Over the same period, the number of children of JSS age increased from 595,000 to 1.3 million and from 476,000 to 1.6 million in senior secondary school. This doubling of the school going age population is the outcome of high population growth through high fertility and declining mortality in the period concerned.

Table: 1 Changes in Ghana's population of school-going age, 1970-2000

Year	Primary (6-11)	Junior Secondary School (12-14)	Senior Secondary school (15-18)
1970	1,533,734	594,618	476,101
1984	2,166,482	910,139	761,101
2000	3,154,146	1,321,159	1,583,615

Source: State of Ghana Population report, 2003

One of the population policy goals is to increase the proportion of females entering and completing at least senior secondary school. In line with this goal, the policy's education target is to increase the proportion of 15-19 year old females with secondary education and higher by 50 percent by 2005 and up 80 percent by 2020. In 1997, the Ministry of Education (MOE) established the girls' education Unit of the Ghana Education Service (GES) to increase the enrollment of girls in schools to equal that of boys by the year 2005. It was also tasked to reduce the drop out rate for girls from 30 percent to 20 percent in the primary schools and in the Junior Secondary School (JSS) from 29 percent to 15 percent.

Considerable progress has been made in this area. For example, while in 1990/1991, girls' enrolment at the primary level was 45 percent, the percentage in 2000/2001 was 47.2 percent. That of JSS went up to 45.3 percent in 2000/2001 from 40.8 percent in 1990/1991. The Science, Technology, Mathematics and Education (STME) clinic for girls was instituted in 1987 to promote the interest of girls in Science Technology and Mathematics education and also, enable them to interact with women scientists and technologists. The clinics were decentralised to the district level in 1997 and has resulted in an increase in the number of girls pursuing science and technology related courses in secondary schools as well as the universities.

Several programmes were undertaken under the affirmative action policy to bridge the gap between males and females. For instance, the University of Ghana has a policy to encourage the enrolment of females at the University. The cut off grades for females are lowered to give more

room for female students entering the university. For instance, during the last admission process, the aggregate cut off point for admission to the university was 15 for females and 16 for males..

In the 2003/2004 academic year, government introduced the capitation grant policy initially to 40 most deprived districts in the country since then, the programme has been expanded to include all 170 districts of the country. in support of governments policy for free and compulsory education, in July 2005, the Ministry of Education announced that all parents of wards in public basic schools would as from September 2005, not pay any fees towards education of their wards. This policy increased enrollment by 15 percent across the country Several reports suggest a marked increase in primary school enrolment since the 2005/2006 academic year. . However, the number of teachers to cater for these new numbers is yet to be addressed in ensuring quality of education received. Closely linked to the capitation grant is the school-feeding programme The programme was set up to provide one hot meal a day for pre and primary school children. Currently, plans are underway to take schools in affluent urban communities off the programme in order to maximize its availability to pupils in poorer and rural areas.

In 2011, government launched a basic school computerization project to distribute more than 60,000 computers to public basic schools throughout the country to enhance and facilitate teaching and learning. The project will benefit 13,000 primary and 8,000 junior high schools. The project forms part of the e-school policy and programme of the MOE to enhance computer literacy and learning in basic schools.

In order to address weaknesses in the educational system, the government carries out periodic policy and programme reviews. It is suggested that Distance learning programmes should be expanded at all levels so that potential students who do not have the opportunity to be in the classroom can have access to formal education. In addition, the The capitation grant, the provision of school uniforms and the school feeding programme have facilitated high school enrollment in primary schools. Efforts should be made to retain these pupils in school beyond the primary level. When students enroll at the second cycle level, they are likely to enroll in tertiary schools even if not immediately after completing the second cycle level.

4.2   Literacy

In 1948, only four percent of Ghanaians had ever been to school. Despite significant improvements since the situation leaves much to be desired with 42.6 percent of the population aged 6 still illiterate. Indeed the absolute numbers of illiterate people in Ghana rose in 30 years from 3,791,762 in 1970 to 6,635,168 in 2000. This increase was partly due to high population growth rates and the inability for government to keep up with the pace of education for such numbers (SGPR, 2006). The decline in illiteracy is a result of increases in school enrolment. Since independence, various governments have put in place educational policies and programmes that focus on preparing the population for national development.

Figure 5   Literacy rates for Ghana, 2000
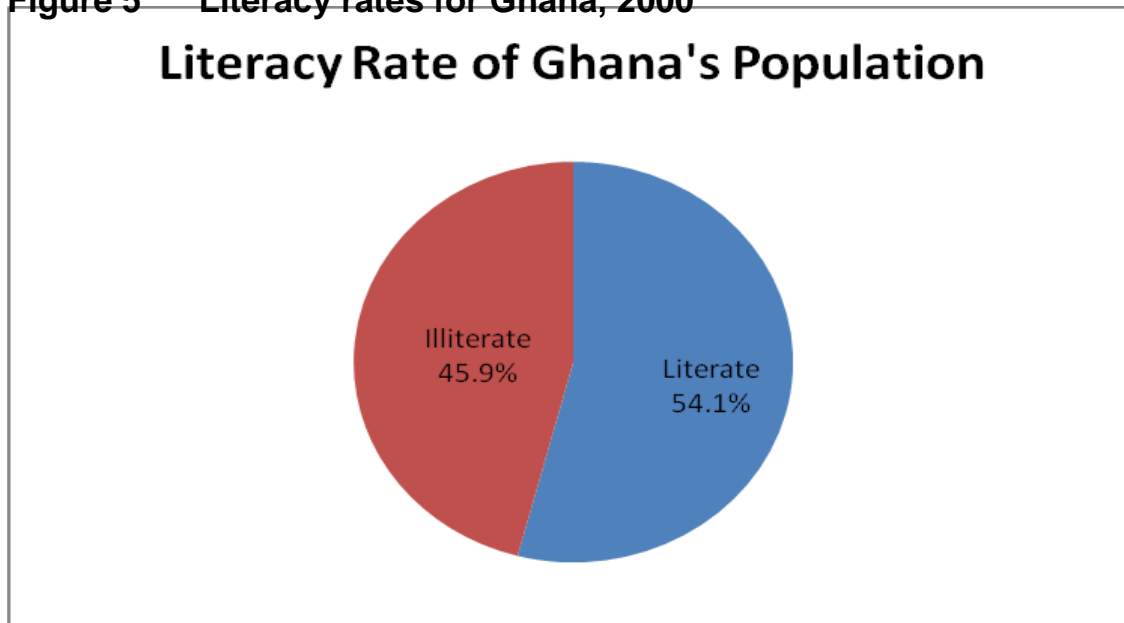
Source: State of Ghana Population report (2003)

As at the year 2000, 45.9 percent of Ghanaians were illiterate while the remainder were literates as illustrated in figure1.Illiteracy among Ghanaian adults (15 years and older) is still high. The 2000 Population and Housing Census results show that illiteracy is more prevalent among adult Ghanaian females (54.3 percent) than males (37.1 percent). This low level of literacy among females has far reaching consequences for demographic processes such as fertility behavior, mortality prevalence as well as sustainable development. Illiteracy among adult females tends to

be associated with high fertility and high maternal mortality and low level of empowerment. These tendencies make it difficult for women to utilize their full potential in the development process.

Table 2 indicates that a high rate of illiteracy exists among females. This huge deficit is among rural and urban poor women which deny them full participation and partnership in economic and social issues in the country. This results from lack of access to education in childhood and opportunities for future learning owing to time constraints.

Table 2 Literacy rates for adults, 15 years and over by sex

Literate 15 years and over (National)	Total percent	Male percent	Female percent
Not Literate	45.9	37.1	54.3
Literate in English only	12.7	14.4	11.1
Literate in Ghanaian Language only	6.4	6.1	6.7
Literate in English and Ghanaian Language	34.2	41.6	27.2
Literate in other Languages	0.8	0.9	0.7
Total	100.0	100.0	100.0

Source: Population and Housing Census (2000)

The functional literacy programme in Ghana aims to increase the number of Ghanaian adults (15-45 years) particularly women and rural poor to acquire literacy and functional skills. The core project design rested on teaching basic literacy and functional skills to adults in 15 Ghanaian languages. In addition, the project aimed at strengthening the radio broadcasting component as well as the broader literate environment in order to sustain project outcomes in the long run. In addition, participating groups were to be encouraged to undertake Income Generating Activities (IGAs) such as animal rearing, palm oil processing and mat weaving. The project was also to deliver a pilot in English literacy based on demand.

When the first phase ended in 1997, it had enrolled 1.3 million adults and trained them in basic literacy and functional skills (in areas such as health, nutrition and sanitation, and environmental cleanliness.

The second phase of the programme was launched in 2000. Its aim was to educate about one million non-literate adults, especially rural and poor women by 2004. In December 2004 the period was extended to December 2006.The project recorded some achievements. Female participation was greater than that of males 60 percent and 40 percent respectively. It also resulted in behavioral changes and better awareness in areas such as health and child care, schooling of children and decision making and participation. The programme was well targeted to women in the productive age group and in the rural areas. There were some challenges as well. Despite the fact the programme was targeted at women in northern Ghana, the programme difficulties were experienced in enrolling women from this region. . In expanding the programme it is recommended that more efforts should be made to provide access to credit and find markets for the produce of their learners. District Assemblies should be encouraged to provide support in diverse ways to the functional literacy programme for the sustenance of the programme.

4.3   Labour Force and Employment

The National Employment Policy (first draft, version 4) of the Republic of Ghana states that the policy is "a bold attempt of government to provide the needed policy response to the precarious employment situation and to assist the poor and unemployed to take advantage of the opportunities to be gainfully employed and contribute their quota to the national development process". The policy further states that achieving the goal of full freely chosen productive employment is not an easy task for a growing economy such as Ghana's. It is the intention of government, however, to overcome structural impediments in the economy and make the ultimate development goal of full employment attainable through the effective implementation of the National Employment Policy.

In 1984, the active population (15-64 years), which constitutes the bulk of the labour force, was 6.3 million (51.2 percent of the population). This increased to 10.1 million in 2000 (53.4 percent of the population). By inference, the age dependency ratio reduced from 95.3 percent in 1984 to

87.3 percent in 2000. The increased labour force size and a declining dependency ratio suggest fertility reduction, which is shown by the reduction in total fertility rate from 6.4 in 1988 to 5.5 in 1993, 4.6 in 1998, 4.4 in 2003 and 4.0 in 2008 (Ghana Statistical Service and Macro International, 1989, 1994, 1999, 2004 and 2009).

In spite of the observed decline in both dependency ratio and fertility in the country, unemployment has shown some increases during the same period. The 2003 State of Ghana Population Report, quoting 1984 and 2000 census figures, reports that, unemployment in the country increased from 2.5 percent of the labour force in 1984 to 8.6 percent in 2000, with the number of jobless persons growing from 158,000 in 1984 to 870,000 in 2000. The number of jobless people could even be higher now. In 2002 when government undertook the registration of the unemployed, it recorded 903,437 persons (58 percent male and 42 percent female) actively looking for jobs. The aim of this exercise was to assess their skills for training. Although the Ministry of Manpower, Youth and Employment (MMYE) reports of some training programmes for those with little or no skills, not much is known of where those trained are working and whether the training programmes have been sustained since 2002.

More than half (52 percent) of registered unemployed persons have no skilled trade or training, while close to a third are unable to read at all, suggesting that they have little or no education; such unemployed persons therefore become ineligible for employment in jobs requiring some training or skills. The unemployed situation in Ghana, therefore suggests that apart from there being increases in the number of persons unemployed or underemployed, the level of education and training of the unemployed is also quite low. This means that the issue of unemployment may be more that of training/education than of lack of absorptive capacity.

About 30,000 youth are reported to have trained in trades including carpentry, masonry and tie and dye batik making. Tracer studies that have been undertaken by the Ministry suggest that most of those trained have been into self-employment. The problem, however, is with inadequate state support and capital for trainees to start work. As part of the training at all levels of education, students should be sensitised not to look for employment only in the but in the

informal sectors as well. In addition, students should be encouraged to be self employed themselves instead of being employed by others.

4.4   Reproductive health

The proposition of Reproductive health (RH) is that people are able to have a satisfying and safe sex life and that they have the ability to reproduce and the freedom to decide whether, when and how often to do so. The country therefore approves of the principle that RH Care is a constellation of preventive, curative and promotional services to improve on the health and wellbeing of the population particularly, mothers, children and adolescents. In 1978, the primary health care concept was adopted with maternal and child health care services, however, in the 1980s, there was focus on child survival strategies and programmes with the objective of reducing infant and child morbidity/mortality. The concept of bringing together maternal and child health/family planning represented the first attempt of combining two components to deal in a more comprehensive manner with aspects of RH (child birth, child/maternal health and family planning).

The country's organized Maternal and Child Health (MCH) started in the 1920s and by 1972, there were 416 institutions offering services to mothers and children. In 1970, the country established the Ghana National Family Planning programme (GNFPP) under the Ministry of Finance and Economic Planning since family planning was a fundamental human right of individuals and couples. The MCH and GNFPP were later merged under the Ministry of Health to become MCH/FP.

After the ICPD, there was a move from MCH/FP to a broader RH setting. To ensure an effective RH care of the population, there are various policies that guide implementation of programmes such as the national reproductive health service policy and standards (that provides explicit direction, framework and focus to training and service provision of RH) and national reproductive health service protocols (which provide standard guidance to service provision covering all components of RH). The Reproductive Health Strategic Plan (2007-2011) provides the framework for achieving the vision of improving health status and reduces inequalities in

health outcomes of all people living Ghana. The Safemotherhood programme was started in 1987 as a component of the larger reproductive health programe. The national (RH) policy recommends a minimum of four visits during pregnancy. In 2009, 92.4 percent of expected pregnancies were registered for antenatal, an increase from 88.7 percent in 2005. About 82 percent of registrants made at least four visits in 2009. The free maternal care services introduced by the government with support from Department for International Development (DFID) have improved access to maternal health services significantly.

Antenatal care services are provided by public health facilities, Christian Health Association of Ghana (CHAG) and other Faith Based facilities, Teaching Hospitals, Quasi-government facilities and private healthcare facilities including private maternity homes. In places where these health facilities are not available, trained TBAs are supported to provide ANC services within their capabilities in the communities. The maternal mortality ratio reduced markedly from 740 to 350 per 100,000 live births from 1990 to 2008   while under-five mortality reduced modestly from 110 to 80 per 1000 live births within the same period. These achievements were accrued from the various policies, strategies and programmes put in place.

The policy and strategies for improving the health of children under-five was developed due to the vulnerable nature of the under-five age group who contribute to more than half of deaths in all ages. The policies focus on neonatal health care, prevention and control of growth and nutritional problems, prevention and control of infectious diseases and injuries, clinical care of the sick and injured child and health related interventions. The following are some Integrated Maternal and Child Health Campaigns organized in the country and which have received encouraging results:

- Polio immunization for children from birth to 5years
- Vitamin A Supplementation for children aged 6months to 5years
- Vitamin A Supplementation for lactating mothers within 8 weeks of delivery
- Deworming for children aged 2years to 5years

Abortion although illegal in Ghana (criminal code, 1960), is permitted under certain stipulated conditions such as the pregnancy being as a result of rape or defilement or the pregnancy being detrimental to the physical or mental health of the pregnant woman. The reproductive health programme includes the provision of safe abortion services including post abortion care (PAC). Unsafe abortion is a major cause of maternal mortality in Ghana. The GHS developed a strategic plan in 2003 to combat the high levels of unsafe abortion in the country.

The population policy recognizing the importance of family planning to population management had an objective to ensure accessibility to, and affordability of family planning means and services for all couples and individuals to enable them regulate their fertility and to provide fertility management programmes that will respond to the needs of sterile and sub-fertility couples to achieve satisfactory self-fulfilment.

Although the country is on track regarding its targets for fertility, indicators for contraceptive prevalence do not paint the same picture. The current family planning acceptor rate reduced from 33.8% in 2008 to 31.1% in 2009 (2009, Service Statistics, Ghana Health Service) and preference for shorter term methods continues to remain high compared to other modern methods. The use of contraceptives in Ghana for any family planning method is 24%, while that of any modern method is 17%, a reduction from 19% in 2003 for modern methods (2008 GDHS).

Barriers to the use of family planning, exists among various categories of people such as, service providers, community and family members, and also among individuals. Misconceptions and the barriers could be employed as opportunities as new strategies in addressing the gaps in family planning implementation. The main reasons for not intending to use contraception in the future among currently married women are;

- fertility-related reasons (e.g. sub fecund, want of many children)
- opposition to use (e.g. respondent and partner opposed)
- lack of knowledge (e.g. knows no method and source)

- method-related reasons (e.g. fear of side effects and health concerns).

A Road Map for Repositioning Family Planning in Ghana was launched by the Ghana Health Service in 2006 for a five year period (2006 to 2010). This was to reemphasize the importance of family planning in both health and socio-economic development. The aim is to ensure that family planning becomes the focus for strengthening and advancing reproductive health care and rights. The period of implementation of the road map has been extended and incorporated in the medium term policy framework

4.5   Prevention of mother-to-child transmission (PMTCT) of HIV

This intervention has the goal to reduce mother-to-child transmission of HIV and improve health service provision and psychosocial support for mothers and children. The number of health facilities providing Prevention of mother-to-child transmission (PMTCT) services increased from 408 in 2007 to 793 in 2009. The number of women counselled and tested also increased from 104,045 to 381,874 during the same period. The HIV positive rates among these women were 3.2 percent and 1.7 percent in 2007 and 2009 relatively. The observation is that the number of ANC clients accepting counselling and testing services increased over the three year period but there was a decrease in the number of women on ART in 2009 as compared with the two previous years. All regional hospitals and most district hospitals are currently providing antiretroviral therapy services for HIV positive clients. HIV positive clients are therefore encouraged to access these sites to receive the needed care and support.

Backing this is the National HIV and AIDS Strategic Plan (NSP 2011-2015) which has the guiding principle that HIV is a developmental issue and public health challenge and so should be handled as such. It has the objective to reduce new HIV infections by 50 percent by 2015 (including PMTCT) and reduce morbidity and mortality among people living with HIV (PLHIV). The National HIV/AIDS and STI Policy also creates the necessary conducive environment, through advocacy for issues such as: ensuring sustained political commitment and support for effective action against HIV/AIDS/STI; providing the conditions for behavioural change in all areas of sex and reproductive health and ensuring consistent programme of

information and education about HIV/AIDS/STI among the general population, especially among women and youth.

4.6   Age at cohabitation or marriage

Marriage marks the point in a woman's life when childbearing becomes socially acceptable in Ghana. Fertility is directly determined by a number of factors which in turn are affected by many social, cultural economic, health and other environmental factors. Characteristically, developing countries have high poverty levels and this breeds lifestyles associated with high fertility because traditional societies tend to perpetuate pronatalist's cultural beliefs. These beliefs keep birth rates high and favour large families. For example, all women want to marry and many couples will like to have at least a male child. Marriage is geared towards the achievement of large family sizes. This is inspite of the children's act setting a minimum age at marriage. Section 14.2 of the Childrens' Act (Act 560 of 1998) states "The minimum age of marriage of whatever kind shall be 18 years".

The 1994 revised national population policy has among its targets to reduce the proportion of women who marry before age 18 by 50 percent by year 2000 and by 80 percent by the year 2020. Another policy target is to reduce the proportion of women below 20 years and above 34 years giving births to 50 percent by the year 2010 and to 80 percent by the year 2020. Judig from progress achieved so far, it it likely that these targets may not be achieved. The most significant social and demographic variables that influence age at cohabitation or marriage are current age, education, place of residence, occupation, and religion. Education for instance has been found to have the most important impact on fertility. It transforms people from economic dependency to self-independence through its effects of creating opportunities for employment and empowerment for self-reliance, which ultimately delays marriage, and for that matter cohabitation. Place of residence has also been documented as having some influence on the timing of marriage. Also, polygyny, a phenomenon in Ghana has implications for frequency of sexual activity and consequently fertility levels. According to the 2008 GDHS, the proportion of married men reported having two or more wives is higher among older men, men in rural areas, those who reside in the Volta and the three northern regions, those with no education and those in the lowest wealth quintile.

Early age at first marriage is an important fertility indicator not only because it increases the length of time a woman is exposed to the risk of pregnancy but it also tends to lead to early childbearing and higher fertility. The median age at first marriage for women aged 25-49 was 19.8 years in 2008 which is a slight increase over the median age reported from the 2003 GDHS (19.4). According to the report, across all age groups, the proportions of women married are larger than the proportions of men married.

According to the 2008 GDHS report, median age at first marriage is consistently lower among women in the rural areas than those in urban areas. There are equally regional discrepancies ranging from 22.9 years in Greater Accra to 17.8 years in Upper East region among women aged 25-49. It was also noted that women with little or no education are more likely to marry at a younger age than those with higher levels of education. As mentioned earlier, the report confirmed that because of poverty, women with low levels of income are likely to marry earlier than women in the higher income class. Comparing the 2003 and 2008 GDHS results, there are indications that over the past five years, both men and women have been marrying at later ages.

Age at first sexual intercourse is another indicator of a woman's exposure to the risk of pregnancy than age at first marriage. Although in Ghana sexual relations with a girl less than 18 years is considered as rape, the 2008 GDHS report that by age 18, more than two-fifths of women (44 percent) and 26 percent of men (married/unmarried) have had sexual intercourse and nearly all men and women are sexually active by age 25.

4.7 Opportunities for birth spacing and reinforcing the value of small families

The overriding objective of the government of Ghana's economic development programme is poverty reduction and general improvement of the welfare of all Ghanaians. Among other things, the revised policy aimed at reducing Total Fertility Rate (TFR) from 5.5 in 1993 to 5.0 by the year 2000, and 4.0 by 2010. The policy accordingly aimed at increasing contraceptive prevalence rate (CPR) to 15 percent for modern method by the year 2000 and 28 percent by 2010. The revised population policy of the government does not only include targets but also

states the means for facilitating the fertility decline in Ghana. Under the sub-heading: women empowerment in the policy document, one incentive for small family size stated that "the number of paid maternity leaves will be limited to three during the entire working life of those affected and no payment will be made in respect of any number of leaves beyond this limit." However, this and other interventions put in place in the policy to address large family sizes are not being implemented.

It is worth noting that the country has made some progress in reducing fertility. The GDHS results showed a decline in (TFR) from 6.4 births per woman in 1988 to 5.5 in 1993, to 4.6 in 1998, to 4.4 in 2003 and 4.0 in 2008 indicating that, there was a minimal drop between 2003 and 2008.   Although fertility is declining in Ghana, it is still high, particularly among some geographic groups. For example, the regional disparities range from as low as (2.5 per woman) in the Greater Accra Region to as high as (6.8 per woman) in the northern regions. The increase in human numbers is a source of concern to policy makers and planners because of lack of commensurate increase in available resources, which affect the quality of life of the people. Furthermore, according to the 2008 GDHS report, about 35 percent of married women have an unmet need for family planning. Unmet need for child spacing is higher than the unmet need for limiting children (23 percent and 13 percent) respectively. However, between 2003 and 2008 contraceptive prevalence rate (CPR) declined from 19 percent to 17 percent. This has also been a cause for worry among policy makers. Also, only 40 percent of demand for family planning is currently being met, implying that the needs of more than one in two Ghanaian women are currently not being met.

4.8   Adolescent reproductive health

According to the 2008 GDHS one in ten (10 percent) teenagers has already had a child and another 3 percent are pregnant with their first child. Births to teenage mothers (age 15-19) have been found to have the highest infant and child mortality in Ghana (GSS and MI, 1994 and 1999). The 2007 Ghana maternal health survey depicts that 15 percent of all maternal deaths in Ghana are to adolescents. Out of the total 889 maternal deaths recorded in 2009, 72 were found to be adolescents. This may be due to the fact that these young mothers being more likely to

experience complications during pregnancy and delivery than older mothers, resulting in higher morbidity and mortality for both themselves and their children.

According to the United Nations Population Fund (UNFPA), sub-Saharan Africa has the lowest demand (30 percent) and use (20 percent) of contraceptives among 15-19 year olds contributing to high rates of adolescent pregnancies. Evidence from the GDHS (2008) indicates that more sexually adolescent males than females use modern contraception (86.7 percent for males and 32.8 percent for females). This heightens the problem of adolescent pregnancies as the unmet need for contraception remains high among female adolescents. The government has strengthened its efforts to curb the difficulties facing the youth in various aspects of reproductive health, this it does through the various ministries, agencies and departments. These agencies such as Ghana Health Service (GHS), CHAG, PPAG, help in championing the cause of adolescent health in Ghana.

4.8.1 Demographic and social factors associated with Adolescent Pregnancy

Certain socio-cultural and demographic factors continue to pose as challenges in addressing the reproductive health needs of Ghana's young people. These challenges include early age at first marriage, early age at first sex, increasing indulgence in premarital sex and low use of contraception. Data from the Ghana Demographic and Health Surveys (1998, 2003 & 2008) show an increasing age at first sexual intercourse; marriage and childbearing. As indicated in Table 3, the age at first sex has increased over the years (from 17.5 years in 1998 to 18.3 percent in 2003 and 19.2 percent in 2008). Though the increment is gradual, the target as stipulated in the Adolescent's Reproductive Health Policy to motivate young people to increase the age of onset of sexual activity from around 12 years to over 15 years by 2010 has been achieved. Again early births for the female population below 20 years (adolescents) have declined tremendously over the years (1998-2008). In 1998, early births was peaked at 32 percent. This reduced to 23 percent in 2003 and further declined to 13 percent in 2008 indicating that some sexually active adolescents are postponing childbirth. These average successes have been achieved due to the

strategies and effective programs being put in place by stakeholders' including CHAG, PPAG and Alliance for Reproductive Health.

Table3:   Demographic and Social factors associated with adolescent pregnancy

	Years		
Fertility Indicators	**1998**	**2003**	**2008**
Age at first sex	17.5 years	18.3 years	19.2 years
Age at first marriage	19.1 years	19.6 years	20.1
Early births <20 years	32%	23%	13%
Adolescent Birth Rate	90/1000	74/1000	66/1000
Adolescent Contraceptive use	5%	6.9%	8.5%

Source: Ghana Demographic and Health Survey Reports (1999, 2004, 2009)

4.8.2 Policies and existing programs on Adolescent Health Promotion and Advocacy

4.8.2.1   Government of Ghana

In its efforts to ensure the health and development of adolescents in Ghana, the Government of Ghana developed a 7-year (2009-2015) National Strategic plan for the Health and Development of Adolescents and Young People. The plan emphasises their right to information and education, life and livelihood skills, leadership skills, youth friendly services and counselling, safe and supportive physical, psychological and social environment as well as opportunities to participate in programs that affect them (Standards and Tools for Monitoring Adolescent and Youth Friendly Health Services in Ghana, 2010) .

The Adolescent Health and Reproductive Health Programs in Ghana are making strides in promoting the objectives of the National Strategic plan in health and development of young people. Youth corners and youth friendly services are being established nationwide by the GHS, CHAG and PPAG. Analysis of the progress of the regional youth corners, as reported by the

annual Adolescent Health Development Program (AHDP) 2009 shows that 129 youth corners are functioning nationwide. Some of the regions are noted to have had all their youth corners functioning while others had only a few or none of its youth corners functioning. Ashanti Region had only 3 out of its 17 Adolescent Health Corners (ADH) Corners functioning while the Western Region had none of its youth corners' functioning. The three Northern Regions however had all of their youth centres functioning as at 2010.

The Ministry of Health and its partners have implemented a number of adolescent reproductive health actions recommended in the Adolescent Reproductive Health (**ARH**) Policy. The goals of the ARH policy (NPC, 2000) enjoins all stakeholders as well as the private sector to participate actively in the formulation, implementation, enhancement and expansion of the sexual and reproductive health programs for adolescents and young people. These programs are found in the broad areas of education (school curriculum for basic education, and other informal settings), media campaigns, counselling, youth development, peer education and service provision. The challenge is to ensure the translation of all policy objectives into effective programs and activities.

4.8.2.2 Activities of Non- Governmental Organizations in Adolescent Reproductive Health

Various NGOs have contributed and are still contributing to the promotion of adolescent reproductive health programs and activities in Ghana. They continue to advocate for the need to put adolescent sexual and reproductive health issues constantly on the development agenda of the country. The 'Young and Wise' campaign and Youth Action Movement of Planned Parenthood Association of Ghana for instance provides sexual and reproductive health information, counselling and services at special youth-friendly service centres. The 2009 annual report of the AHDP indicated that all the four Youth centres of PPAG were functioning. CHAG was also noted to have established three new corners in Catholic facilities although two closed down due to lack of funds.

In the Ashanti region, the Role Models foundation, (an NGO) as reported in the AHDP annual report (2009) organized a series of lectures for in and out-of -school youth. The topics included prevention of STI/HIV, drug abuse, unsafe abortion and adolescent pregnancy. In all 2,935 adolescents were sensitized. A 'know your status' campaign was done for adolescents during which 3,921 males and 15,469 females were counselled and tested for HIV. In all, 2,935 young people were educated on drug abuse, HIV, unsafe abortion and adolescent pregnancy and its effects.

In the Upper East region, a 'Know your HIV Status' campaign, abortion care, family planning and personal hygiene information were provided for young people. In the Northern Region, 101 peer educators were trained bringing the number to a total of 507. Out of these, the World Vision and Markazal Bishara (NGOs) were noted to have trained 51 peer educators during the year 2009. A total of 18 youth clubs were formed. In the Brong Ahafo Region, sensitization of young people on adolescent health issues in churches and different apprenticeship groups was carried out in all districts. Topics discussed included family planning, induced abortion, personal and environmental hygiene. In all 16,600 pieces of condoms (male and female were distributed to young people. (AHDP annual report 2009)

In the Volta region, four community durbars were held and three football competitions organized and used as entry points for health education. Topics discussed include STIs and HIV/AIDS and personal hygiene. A total of 37 peer educators were trained and provided with some logistics including bicycles to enhance community work. In the Central region, 'Time with Grandma, a community- based adolescent health education program using strategies of African folklore and storytelling was carried out in 7 out of 17 districts.

Table 4:   **Number of regional persons available, trained frontline workers and functional ADH Corners, 2009**

Regions/ Institutions	No of regional persons available	No of trained frontline health workers	No of functional ADH corners*
Upper East	16	92	4
Upper West	15	-	3
Northern	34	72	12
Brong Ahafo	1	N/A	3
Ashanti	8	N/A	3
Volta	10	N/A	34
Eastern	17	197	54
Central	3	N/A	15
Western	2	-	0
Greater Accra	5	9	9
PPAG	-	-	4
CHAG	20	N/A	11
Total	133	370	129

Source: Adolescent Health and Development Program annual Report 2009
*The data is for 2010.

4.8.2.3   Proposed strategies

Evidence from the GDHS suggests that the adolescent population who are most at risk of adolescent pregnancy are the poor (both urban and rural ethnic minority, and youth with limited opportunities). Strategies must therefore target in-school adolescents, out-of-school adolescents and special groups as defined in section 5.0 of the adolescent reproductive health policy. The proposed strategies are discussed in the areas of youth development, education, access to reproductive health information and research, monitoring and evaluation.

4.8.2.4   Youth Development

In line with the public health framework towards adolescent pregnancy prevention, the primordial prevention strategy which seeks to address adolescent poverty through livelihood skills, education, gender and other traditional programs should be strongly featured in addressing adolescent pregnancy. This strategy can contribute to the delay in initiating sexual activities and preventing pregnancy and STIs through primary and secondary abstinence. A more concerted effort should also be made by all stakeholders to promote economic opportunities and future life options for adolescents.

The National Youth Employment programme is already making headway as more of the youth and especially adolescents find themselves in employable skills thereby reducing their dependence on others. The programme could be strengthened by including a combination of job readiness training, that is, training for readily available jobs, youth-led business ventures, peer teaching or counselling (as done by PPAG Young and Wise/ Youth Action Movement), and life planning skills.

4.8.2.5   Access to Contraceptives and Reproductive Health Care Information

Adolescents are gradually becoming more knowledgeable about reproductive health issues, as more programs are been targeted to reach them. As indicated in Table 4, significant gains have been made over the years in the exposure of adolescents to knowledge on safe sex and use of contraception (From 5 percent in 1998 to 6.9 percent in 2003 and 8.5 percent in 2008). Adolescents may however have concerns about the cost, confidentiality, and accessibility of family planning services that may prevent them from accessing these services from the providers.

One of the specific objectives of the ADHD programme as stated in their 2009 report is to increase young people's access to general health services including sexual and reproductive health care in 25 percent of health facilities and outreach points by the end of the year 2006, 50 percent by the end of 2015 and 100 percent by end of year 2020. As shown in the table above, access to and utilization of health services by adolescents are very poor. Some of the Adolescent Health (ADH) Corners in the regions have been closed down due to inadequate availability of

human, material and financial resources. The number of resource persons are said to be decreasing as a result of transfers, retirement and pursuit of education. Other offices of the youth centres as noted in report now serve as canteens and some been converted into NHIS offices.

This however shows a weak system support for program me activities and would definitely not lead to a desired policy outcome. Efforts should be made to replace resource persons as soon as they go on transfer or retire from active service. Further, adequate funding should be allocated to the AHDP in order to promote the establishment of more youth centres/corners particularly in regions that had the least number of youth corners (Ashanti and Western) as well as encourage the expansion of existing ones to provide a wide range of services including counseling on sexual and reproductive health to adolescents and young adults.

4.8.2.6   Sexuality Education

As part of the efforts being made by the Ghana Education Service (GES) towards the incorporation of sex life education into the GES syllabus, the GES should strengthen its efforts in the expansion of and diversification in the existing programmes to reach out-of-school adolescents so they could also benefit immensely from sexuality education. This could be offered outside of school settings in order to target harder-to-reach teens and teens at higher risk of early pregnancy.

Again, training programmes for teachers should be strengthened to enable them to effectively teach sexuality education especially those relating to adolescent sexual and reproductive health. In accordance with the Primary Prevention Public Health framework to adolescent pregnancy, the training should include interpersonal and communication skills that will help young people explore their own values, goals, and options and to make responsible decisions about their sexuality and reproductive health. Adequate funding should also be allocated for monitoring the effective implementation of the sexuality education programs. Again, the Ghana Education Service should take into consideration the feasibility of mandating both basic and senior secondary schools to teach comprehensive sexuality education. Pregnant adolescent youth, as stated in the National Youth Policy should be well catered for and a framework followed to encourage their completion of at least secondary education.

4.8.2.7 Research, monitoring and evaluation

Reliable and timely data are essential elements needed to effectively translate policies into programmes. Periodic research into strategies and programmes available on sexual and reproductive health for adolescents should be encouraged by all stakeholders. The Ghana Statistical Service, Universities, MDAs, NGOs and individuals should also be encouraged to conduct regular researches as well as provide up-date information on adolescent reproductive health needs, behaviour patterns, including those on sexuality.

Furthermore, the key indicators (as specified in the Standards and Tools for Monitoring Adolescent and Youth Friendly Services in Ghana) for monitoring and evaluating the impact of adolescent sexual and reproductive health programs should be strengthened. This is to allow for efficiency and effectiveness of the adolescent reproductive health programme (Section 10.0 of the Adolescent Reproductive Health Policy) Furthermore, all partners in adolescent health should be encouraged to present quarterly reports to the GHS so as to enable them have an up-to-date data or progress report on all programmes in adolescent health being undertaken by non-governmental organizations.

4.8.2.8 Access to Primary Health Services

In adopting the Primary Health Care (PHC) concept, the government acknowledged the need for an integrated, multi-sectoral programme of health and well being of the population, especially those living in disadvantaged communities. Section 5.3.2. of the Population Policy states that, vigorous implementation of a National Health Policy shall be pursued. The implementation of the Primary Health Care System as the main focus of health care delivery in Ghana shall be intensified. Maximum community participation in the formulation and of health services shall be promoted.

In the year 2005, the Government of Ghana began the implementation of the National Health Insurance Scheme (NHIS) after the Bill was passed in October 2003. This was to replace the cash and carry system. Pregnant women were given free antenatal care, delivery and postnatal care. This led to the increase of patients visiting the health facility to seek medical care and the steady improvement in women's health thereby putting pressure on the existing facilities.

The Ministry of Health (MOH) launched the Community-Based Health Planning and Services (CHPS) programme in 1999 to provide community-based health service through partnerships with the health programme, community leaders, and social groups. CHPS compounds are established in areas without health facilities with stationed community Health Officers to attend to the health needs of the people. Basic health care services are integrated with reproductive care services in their line of duties.

The 2008 GDHS shows 95 percent antenatal care was received from a health professional. Differences exist in the use of antenatal care services between women in the urban and rural areas and those with different educational levels. Health professionals provide antenatal care for 98 percent of mothers in urban areas compared with 94 percent of mothers in the rural areas. Mothers with at least some secondary education receive prenatal care services from a health professional compared with 94 percent of mothers with primary or no education.

4.8.2.9   Delivery and Postnatal Care

With the introduction of free maternity services and the introduction of the CHPS compounds which are closer to the people, some barriers for accessing skilled maternity care have been removed. Fifty-seven (57 percent) of deliveries now occur in health facilities (48 percent in the public sector as against 9 percent in the private sector). Home births are much more common in rural areas (58 percent) than in the urban areas (17 percent).

Postnatal care helps prevent complications after childbirth. More than two-thirds of women receive a postnatal checkup within two days of delivery. However 23 percent of women do not receive any postnatal care within 41 days of delivery.

**Figure 6:   Trends in Maternity Care Indicators Ghana 1988-2008**
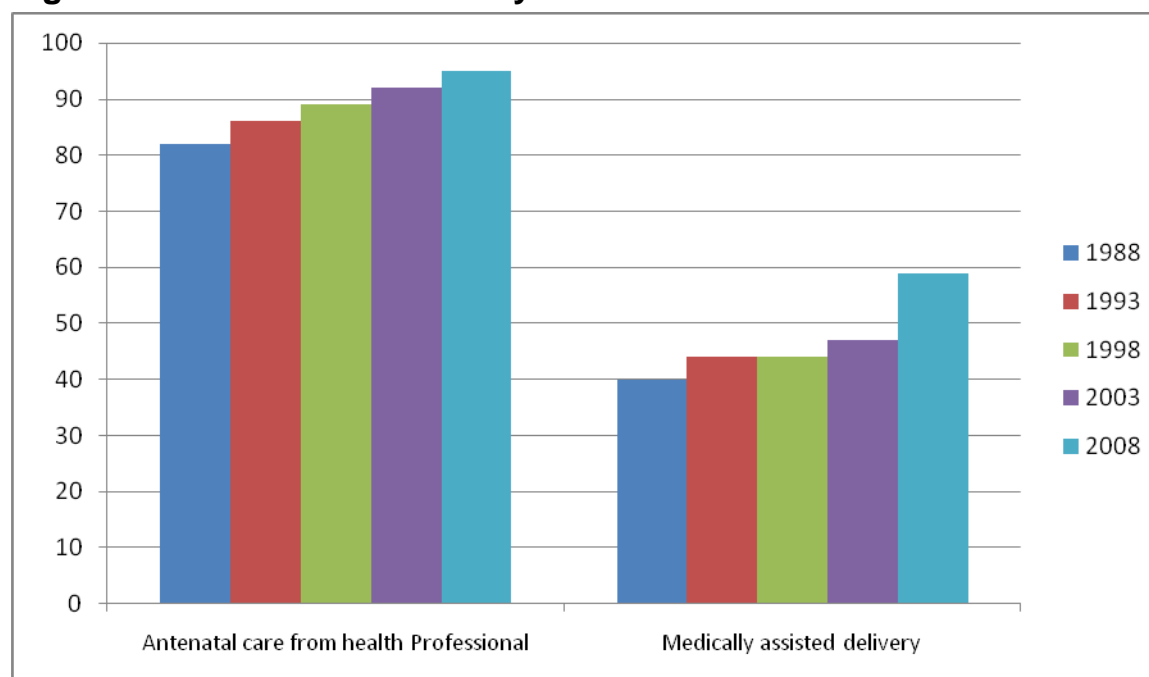
Source: 2008 Ghana Demographic and Health Survey

Figure 2 indicates that there was an improvement of antenatal care from a health professional from 82 percent in 1988 to 95 percent in 2008. There has therefore been a marked improvement in antenatal care coverage in Ghana over the past 20 years. Also, medically assisted deliveries improved from 40 percent in 1988, 44 percent in 1993 and 1998 and then shot up to 59 percent in 2008.

Figure 3 shows the   percentage of type of assistance during delivery for births in the 5 years before the 2008 Ghana Demographic and Health Survey. More than half (59 percent) of births were delivered by a skilled provider (doctor, nurse, midwife, auxiliary midwife and community health officer/nurse. Of the remainder a higher proportion of births were assisted by Traditional birth attendants.

Fig 7: Assistance during Delivery
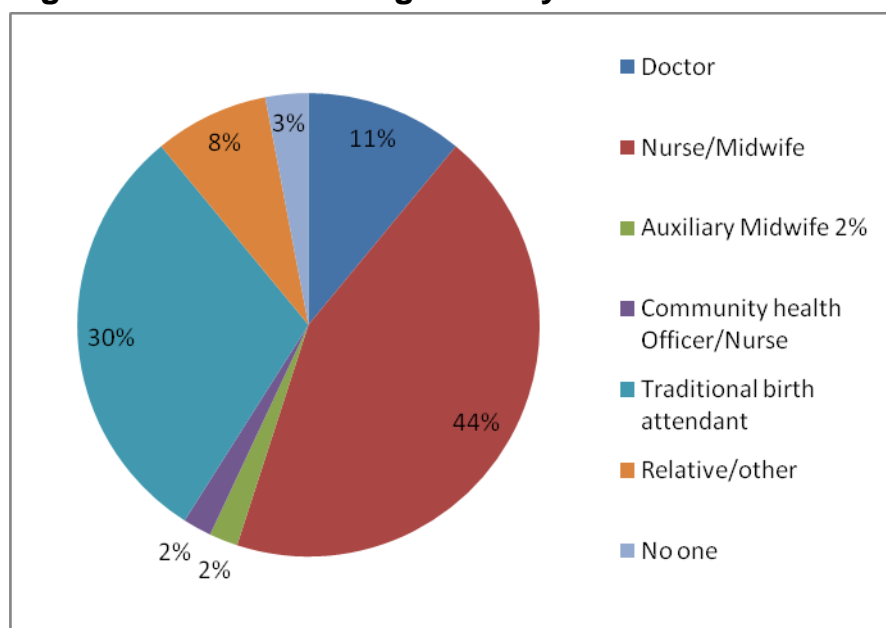
Source: 2008 Ghana Demographic and Health Survey

4.3   Population and gender issues

4.3.1 Role and Status of Women

Given the strategic position of women in the process of human reproduction, gender equality and equity, women's empowerment should be a central policy concern in addressing demographic issues. This has resulted in the shift from emphasis on demographic targets to the promotion of reproductive health and rights as an imperative for the improvement of the quality of life of all people, particularly women and children.

The 1994 Revised Population Policy recognizes the centrality of women's role in production, reproduction and as agents and beneficiaries of socio-economic development and change. It recognizes the disparities that exist between men and women in accessing basic services and economic opportunities. Again, Section 4.2.6 of the 1994 Revised Population Policy states measures that will be instituted by government, in collaboration with traditional authorities and other interested organizations or institutions to enhance the status of women in the society. This was to be done through a wide range of measures such as the elimination of all discriminatory

55

laws and cultural practices which are inimical to the general well-being and self esteem of women and to promote wider productive and gainful employment for women. In addition, it sought to increase the proportion of females entering and completing at least SSS; to develop a wider range of non-domestic roles for women; and to examine the structure of Government conditions of employment and if necessary, change them in a way to minimize their pro-natalist effects.

4.3.2 Economic Empowerment

Section 4.3.11 of the population policy states that, programmes will be developed aimed at the empowerment of women to increase their participation in the modern sector, engage in income-generating activities, and enhance their economic well-being generally. In Ghana, about 51.3 percent of the population are women who make up about half of the entire labour force and are significant contributors to national output growth (IFC report 2007). Most economically active women in Ghana operate in the informal economy, where they outnumber men, and are particularly involved in various micro-enterprises and retail trade, the report states.

Women in Progress/Global Mamas, an NGO has directly enhanced the wages, standard of living, and confidence of over 400 low-income women in Ghana by helping woman-own businesses and expand their operations. Global Mamas exists so women can earn an income and in doing so, gain respect. They are connecting women in Ghana to the global economy and thus to cultures all over the world through the beautifully handcrafted goods the network produces and sells. Furthermore, they are empowering women today who are inspiring tomorrow's female entrepreneurs.

Although there have been a number of donor supported schemes for direct lending, the government at various times has operated lending schemes for Small and Medium Enterprises (SMEs). Some of the schemes include the following:

- Business Assistance fund - operated in the 1990s to provide direct lending to the SME sector. The loans were widely seen to be abused politically with most of the loans going to perceived supporters.

56

- Export Development and Investment Fund (EDIF) – Under this scheme, companies with export programmes can borrow up to $500,000 over a five-year period at a subsided cedi interest rate of 15 percent. While the scheme is administered through banks, the EDIF board maintains tight control, approving all the credit recommendations of the participating banks.

In its contribution towards poverty reduction through women's empowerment, the Ministry of Women and Children's affairs (MOWAC) disbursed over 24 billion cedis to 41,000 women in small-scale enterprises through its first phase micro credit programmme. MOWAC reports that as a result of the project, several farmers have taken to saving in banks and that rural banks were more willing than in the past to extend credit facilities to them, even without collateral.

To help initiate the second phase of the project, the Japanese government provided assistance of 26.5 billion cedis to be distributed through the Women's Development Fund. Reproductive health activities were integrated into the micro-credit scheme. This was to ensure that both the reproductive and productive roles of women were effectively addressed. The Women's Development Fund has been established to provide micro-credit for women. By the end of 2004, 991,000 women had benefited from about $54b, and the recovery range is encouraging. The Ministry of Food and Agriculture has developed skills training and other programs targeted at women. Programmes have also been organized by the Ministry to sensitize extension officers to mainstream gender concerns in their service delivery.

4.3.3 Women in Governance

Article 17 of the 1992 Constitution of Ghana prohibits discrimination on the basis of gender. An Affirmative Action Policy of 1998 provides for 40 per cent quota of women's representation on all government and public boards, commissions, councils, committees and official bodies including Cabinet and Council of State.There are a lot of organisations advocating for women's rights, but so far ABANTU for Development, through the Women's Manifesto Coalition and Women in Law and Development in Africa (WiLDAF) Ghana, are the two major women's rights

organisations. They have been championing the cause for Affirmative Action Policy for Women's.

CHAPTER 5: FUTURE PROSPECTS AND PROJECTIONS

5.1 Introduction

The main subject of this report relates to the relationships between population and development and their consequences in terms of the standard of living of the population. These relationships determine to a large extent the quality of life of the people which can be measured in terms of income levels, nutritional status, health, education, housing and general welfare. Rapid population growth is one of the factors that make it difficult for the country to realize some of its development objectives and targets.

Ghana currently experiences rapid population growth with high levels of fertility and mortality. The young age structure of the population has a high potential for a rapid expansion of the population in the future. Though surveys have shown a gradual decline in fertility levels since 1988, estimates indicate that the Total Fertility Rate will not reach replacement level of 2.1 live births per woman who passes through the reproductive ages before 2050 (Ghana Statistical Service, 2005: Population Data Analysis Report Vol. 1, Socio-Economic and Demographic Trends Analysis). Fertility, mortality and migration levels and trends are essential information needed for planning for the future. Therefore assessing the future population and other demographic variables would reveal realities that reflect some of the development challenges facing the country. It should be noted that information on international migration are so scanty and unreliable that immigration and emigration are assumed to cancel out and are therefore not factored into projection of the total population.

This chapter presents and discusses the future prospects and projections of Ghana' population. The projections are based on the results of the 2000 Population and Housing Census (data collected in the 2010 Population and Housing Census are currently being processed) and sample surveys conducted to provide information on fertility, mortality, contraceptive usage and other indicators.

5.2   Population Change

One of the major challenges facing Ghana is reducing its high population growth rate which is currently estimated from the preliminary results of the 2010 Population and Housing Census as 2.4 percent per annum, a decrease from the 2.7 percent estimated in 2000. Projections of population growth rates using low, medium and high assumption variants put the population growth rate at between 1.54 percent per annum (low variant) and 2.4 percent per annum (high variant) for 2015. For 2020, the projected growth rate figures for low and high variants are between 1.37 percent and 2.4 percent per annum respectively. Corresponding medium variant estimates for the two projection years are 2.0 percent and 1.9 percent respectively (Ghana Statistical Service, 2005).

The projections using the low and medium variants seem to be on the low side and may not reflect the real picture of the population growth rate in the projection years. Most likely, additional information from the 2010 Population and Housing Census will result in a more realistic revision of the growth rates.

It is estimated and has been articulated at various fora that with Ghana's high population growth rate a GDP growth rate of between 7.0 percent and 9.0 percent (i.e. about between 4.6 percentage points and 6.6 percentage points above the population growth rate) is required to achieve poverty reduction and raise the standard of living of the population. Thus, the 5.7 percent per annum growth in the GDP in 2010 did not meet the criterion for achieving poverty reduction. However, the Ghana Statistical Service has announced that during the first and second quarters of 2011 the growth in the GDP averaged 30.4 percent and 34.0 percent respectively. This sharp increase in the GDP growth rate has been attributed to oil production and the mining and quarrying sectors. If such high levels of GDP growth can be sustained in the future, then there is hope for Ghana's poverty reduction programme.

5.3   Fertility Levels

A marked reduction in fertility levels would substantially reduce the present high dependency burden imposed by the youthful age structure of Ghana's population. The high proportion of people entering the reproductive or childbearing age, which is a key factor influencing the future

number of births, will eventually decrease. The fertility decisions that young people make today will determine to a large extent the demographic scenario of the country in the future. These decisions would depend on family planning information and the range of services made available to Ghanaians, especially young people, to empower them to manage their fertility and to determine the timing and number of children they want.

Fertility levels as estimated by five Ghana Demographic and Health Surveys (GDHS) conducted during the 20-year period from 1988 to 2008, have shown a general declining trend. The 1988 GDHS recorded a total fertility rate (TFR) of 6.4 live births per woman who passes through the childbearing ages – a decline from the estimated TFR of around 7 live births per woman for the period between 1960 and early 1980s. The TFR decreased gradually to 4.4 live births per woman in 1998, remained at this level to 2003, then declined slightly to 4.0 live births per woman in 2008. Based on the assumption that Ghana's fertility level will reach replacement level (defined as a TFR of 2.1 live births per woman) by 2050, TFR has been projected to decrease to 3.8 live births per woman by 2015 and 3.5 live births per woman by 2020.

5.4 Mortality

Levels of expectation of life at birth for the periods 1960-1965 to 1995-2000 have been derived from estimated under-five mortality values based on the North model live tables. Future mortality levels were determined by fitting a logistic function to the estimated mortality values. Two sets of estimated mortality levels were derived: one considering the impact of AIDS and the other set without AIDS. The Table below presents the estimated life expectancies at birth for the periods 1995-2000 to 2015-2020.

Table 1: Estimated and Projected Values of Expectation of Life at Birth

Period (Years)	Without AIDS		With AIDS	
	Male	Female	Male	Female
1995-2000	56.6	60.3	55.0	57.6
2000-2005	58.3	62.0	56.5	59.3
2005=2010	60.0	63.6	585	60.9
2010-2015	61.7	65.2	60.5	62.9
2015-2020	63.6	66.7	62.3	64.2

Source: Ghana Statistical Service, 2005: Population Data Analysis Report Vol. 1, Socio-Economic and Demographic Trends Analysis

Without the impact of HIV and AIDS, life expectancy at birth was estimated at 60.0 years and 63.6 years for males and females respectively during 2005-2010. These are expected to increase gradually to 63.6 years for males and 66.7 years for females during 2015-2020. Incorporating the impact of HIV and AIDS, the projected figures for the period 2015 to 2020 are 62.3 years and 64.2 years for males and females respectively.

The gradual increase in expectation of life at birth corresponds to reduction in the level of infant and under-five mortality over the past two decades. Mortality among infants decreased from 77 per thousand live births in 1988 to 57 live births in 1998, increased to 64 live births in 2003, then decreased to 50 live births in 2008. Similarly, under-five mortality declined from 155 per thousand live births in 1988 to 108 per thousand live births in 1998, rose to 111 per thousand live births in 2003 and decreased again to 80 live births in 2008 (GSS, 2005).

Generally, there has been downward trends in both infant mortality and under-five mortality levels in Ghana. If these trends are maintained into the future, infant mortality rate and under-five mortality rate are expected to reach about 46 per thousand live births and 70 per thousand live births respectively by the year 2020.

5.5   Population Size and Structure

Preliminary results of the 2010 Population and Housing Census put the population of Ghana at about 24.2 million. This implies an average annual increase of about 520,000 persons over the period 2000-2010. The trend in population growth in Ghana is shown in Figure 1 below:

Figure 1: Population of Ghana, 1960-2010
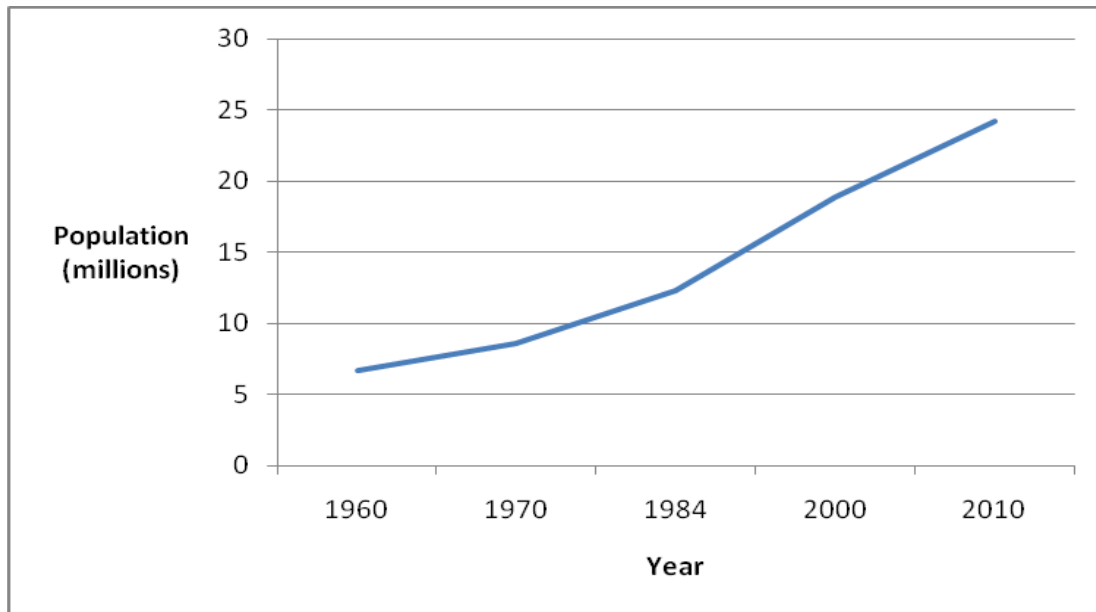
Source: Ghana Statistical Service Census Reports, 1960-2010

The Figure shows that the population of Ghana grew relatively slowly between 1960 and 1970, after which the annual additional numbers increased slightly up to 1984. Between 1984 and 2000 additional numbers increased slightly; however, the scenario during the period 2000-2010 indicates a possible stabilization or reduction in annual additional numbers in the future. If the current trend continues, the population of Ghana will stand at around 28.5 million by 2020.

The population of Ghana is young with a substantial proportion aged below fifteen years. However, over the years, evidence indicates that the age structure of the population of Ghana is changing gradually with the proportion aged below fifteen years declining. This is typical of a population that has begun the demographic transition from high to low fertility. During the transition from high to low fertility levels, populations tend to be characterized by large numbers

of women and men in the reproductive ages, which lead to large numbers of children being born. Women in the reproductive ages (15-49 years) will constitute a comparatively large group in the population. The proportion of the population aged below fifteen years increased from 44.5 percent in 1960 to 46.9 percent in 1970, and then decreased to 45 percent in 1984 and 41.3 percent in 2000. Projections indicate that the proportion the Ghana's population aged below fifteen years will continue decreasing to 34.9 percent by 2020. The population will remain young and therefore will maintain a high growth potential.

5.6   Urbanisation

There have been considerable migratory movements in Ghana since the colonial period. There have been great movements of population from one locality to the other, the more recent movements reflecting the socio-economic changes taking place within the country. Four types of internal migratory movements have been identified: rural to rural, rural to urban, urban to urban and urban to rural. Of these, the most significant in its impact on social and economic development is migration from rural to urban areas.

Ghana exhibits one of the fastest urban growth in the world. In 1960, almost one-quarter (23 percent) of the population lived in urban areas. By 2000, about 44 percent of Ghana's population lived in urban areas, and it is projected that 55.4 percent of the population will be residing in urban areas in 2015, increasing to 59.2   percent by 2020. Internal migration has been a population response to the changing social and economic conditions in the country. As the socio-economic conditions changed, so did the type of migrant and purpose of movement. Urban centres emerged as destinations of the major structural flows of people across the country. Furthermore, urbanization is an integral part of the socio-economic transformation taking place in Ghana, which has led to the redistribution of the population in such a way as to effect more social change.

Urbanisation, as a component of the modernization process, should be seen as a nucleus of the development process to which decision-makers should pay greater attention if the country is to make significant progress toward poverty reduction. The pattern of future development will depend, among others, on the manner in which the country deals with the changing phenomena

of internal migration and increasing urbanization. These observations bring into focus other related phenomena: size, composition and growth of the rural population and their impact on the rural agricultural sector of the economy.

Though there is evidence that the annual rate of the population growth in Ghana is decreasing gradually, it is expected that the actual population numbers will continue to grow rapidly into the foreseeable future. This may be as a result of the persistently high fertility levels and the large numbers of persons aged below 15 years that will be entering the reproductive ages. In order to sustain and also hasten the fertility decline, there is the need to up-scale programmes to encourage more women and men to use contraceptives both as a means of controlling and spacing births. Actions that would retain the girl-child in school up to the secondary or even tertiary level would go a long way in checking the high fertility level.

Survivorship levels expressed as expectation of live at birth has improved over the years, indicating decreasing mortality trend over the period, albeit slowly. With improved health care services and better sanitation, it is expected that the increase in expectation of life will improve significantly in the future, which would reduce the need to have many children as a means of replacing those that do not survive.

Urbanisation, as has been observed, is an integral part of the social and economic transformation taking place in the country. However, cognizance should be taken of the impact of rapid urban growth on the population of rural areas in so far as it affects the agricultural base of Ghana's economy.

Chapter 6:   Conclusions and recommendations

6.1   Conclusions

It is, however, observed that rapid population growth is likely to reduce per capita income growth and well-being, which tends to increase poverty. The effects of poverty become even more serious, especially where there is high rate of unemployment amongst the economically active population of a country. A major contributory factor to the high population growth is the declining but still high fertility levels which is largely responsible for the burgeoning of the young population. The young population implies an in-built population momentum for growth with projections of 35.2 million by 2020.

Ghana is currently experiencing economic growth of between 7 per cent and 13 per cent per annum. This is occurring alongside considerable backlogs in developing human capital, improving living standards, building the needed infrastructure, as well as expanding access to services such as health and education, and to energy. The transition to a more favourable demographic regime will thus remain a critical and difficult period for Ghana for some decades. The demographic transition has more or less stagnated, the challenge, therefore, is whether or not Ghana will be able to stimulate further reductions in fertility and mortality so as to take advantage of the "demographic window of opportunity". For the country to overcome its demographic challenges there is the need to integrate population variables into development planning and policies of major sectors of the economy and at all levels.

As in any other country, especially in the developing world, Ghana's demographic processes play a vital role in its development. In particular, structural changes that occur in the context of rapid population growth have a direct as well as indirect impact on national development. Areas of impact include economic growth, poverty reduction, resource allocation, productivity, and the general welfare and well-being of the population. It is important, therefore, for Ghana to formulate policies and programmes to deal with such issues in order to attain its objective of becoming a higher middle-income

6.2 Recommendations

Despite the checkered results, Ghana is convinced that with continued political will, adequate funding, and integrated package of services, we will record better progress in our population and development indicators.

The above mentioned situation can be improved through

- *Improve sexual and reproductive health*

    Increased attention should be paid by government to the to sexual and reproductive health because an improvement in this area has a direct effect on maternal and child health, as well as on birth rates. the implementation of the Road Map for Repositioning Family Planning should b prioritised including ensuring access and availability of contraceptives,

- *Increase sexuality education*

    Information with regards to sex and sexuality and family planning should be increased. This should enable broader acceptance of smaller family size and provide families and individuals with appropriate information.

- *Ensure Universal Primary Education*

    Education influences a person's behaviour. It is a well known fact that education mortality and fertility decrease with an improved levels of education. In addition, human capital increases. Thus education is one of the key strategies to slowing population growth.

- *Provide micro credits to youth and women*

    The provision of credit to the disadvantaged and vulnerable has yielded positive results. They empower the vulnerable in society and contribute to the improvement in livelihoods including one's reproductive life.

- *Create employment opportunities*

    An economy stands and falls depending on

    Creating employment opportunities must be a priority to offer the teeming youth and women productive employment. It is expected that family sizes will be affected positively when the population is productively engaged.

- *Increase resource allocation to population sector*

Because the population issues are cross cutting, funding for population programmes often is lacking. Governmets, development partners and donors must rethink how population programmes can help them achieve results faster and devote resources for the sector. For eg., appropriate sensitization of the District Assemblies could result in financial support for the integration of population variables in sector programmes at district level, thus tailoring development efforts more closely to people's circumstances.

ANNEX A:

Some key Demographic Indicators of Ghana

No	Indicator	Indicator Level		Source
		2000	**2010**	
1	Total Population	18,912,079	24,223,431	2010 Population and Housing Census. Provisional Results
2	Intercensal Population Growth Rate (percent)	2.7	2.4	"
3	percent of Population Female	50.5	51.3	"
4	percent of Female 15-49 years	47.3	48.4*	GSS, Population Analysis Vol. II: Demographic and Socio-economic Trends Analysis, 2005
5	percent of Population under 15 years	41.3	37.9*	"
6	percent of Urban Population	43.8	51.5*	"
7	Sex Ratio (percent) – males per 100 females	97.9	95.0	2010 Population and Housing Census. Provisional Report
8	Dependency Ratio	71.0	66.0	GSS, Population Analysis Vol. II: Demographic and Socio-economic Trends Analysis, 2005

9	Population Density	79.3	101.6	2010 Population and Housing Census. Provisional Report
10	HIV/AIDS Prevalence Rate (percent)	2.3	1.7	HIV&AIDS Sentinel Survey Report, 2010
11	Total Fertility Rate	4.4	4.0	Ghana Demographic and Health Survey, 2008
12	Infant Mortality (per 1,000)	64	50	"
13	Under-Five Mortality (per 1,000)	111	80	"
14	Contraceptive Prevalence Rate (Modern Methods) (percent)	16.6 (currently Married women) 13.5 (all women)		Ghana Demographic and Health Survey, 2008

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