

Contents

List of Acronyms

Preface

CHAPTER 1: General Background

CHAPTER 2: Analysis of the Trends

Infant and Under five Mortality

Maternal Mortality

Childhood Malnutrition

Immunisation

Eradication of Polio

Elimination of neonatal tetanus

Reduction in measles

HIV/AIDS

Breast-feeding Initiative

Access to safe drinking

Water and sanitation

Guineaworm Eradication

Education

Adult literacy

Iodine Deficiency Disorders

Reproductive Health/Family Planning

Poverty Eradication

The Convention on the Rights of the Child

CHAPTER 3: Cross Cutting Issues

Environment

Gender Considerations

Basic Services

NGOs and Civil Society

Capacity Building

CHAPTER 4: Institutional Response

Introduction

Data Collection Mechanism

Technological Infrastructure

National Dialogue on Database Trends

Feedback into Database

The CCA Process and Country Programming

Framework for CCA Process

Ownership

Shared Information with Development Partners

Mechanism for Programming Purposes

Promoting National Dialogue

CHAPTER 5: Conclusions and Recommendations

Appendix 1: Terms of Reference for the Common Country Assessment Mission to Ghana

Appendix 2: Common Country Assessment Process Note

Appendix 3: Report on the 1st CCA Review Meeting

Appendix 4: Data gaps for the Common Country Assessment

Appendix 5: Database Listing

List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
CBR	Community Based Rehabilitation
CCA	Common Country Assessment
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CHRAJ	Commission on Human Rights and Administrative Justice
CRC	Convention on the Rights of the Child
CSN	Country Strategic Note
DA	District Assembly
DC	Donor Community
DACF	District Assemblies Common Fund
DIP	Divestiture Implementation Programme
DSW	Department of Social Welfare
EAP	Environmental Action Plan
EPA	Environmental Protection Agency
EPI	Expanded Programme on Immunisation
ERP	Economic Recovery Programme
fCUBE	Free Compulsory Basic Education
GDHS	Ghana Demographic and Health Survey
GDP	Gross Domestic Product
GLSS	Ghana Living Standards Survey
GoG	Government of Ghana
GNCC	Ghana National Commission on Children
GNP	Gross National Product
GRMA	Ghana Registered Midwives' Association
GSS	Ghana Statistical Service
GWEP	Guinea Worm Eradication Programme
GWSP	Ghana Water and Sanitation Programme
HDR	Human Development Report
HIV	Human Immuno-Deficiency Virus
ICJCR	International Club of Journalists for Child Rights
ICMMS	Infant Child and Maternal Mortality Survey
ICPD	International Conference on Population and Development
IEC	Information Education and Communication
IERD	International Economic Relations Division
IFAD	International Fund for Agricultural Development
JCGP	Joint Consultative Group on Policy
KAP	Knowledge Attitude and Practice
LSS	Life Saving Skills
MCH/FP	Maternal and Child Health/Family Planning
MICS	Multiple Indicator Cluster Survey
MOE	Ministry of Education
MOFA	Ministry of Food and Agriculture
MOH	Ministry of Health
MMR	Maternal Mortality Rate
MTHS	Medium-Term Health Strategy
NACP	National Aids Control Programme
NCWD	National Council on Women and Development
NDC	National Democratic Congress
NEPS	National Environmental Policy State
NGO	Non Governmental Organisation
NID	National Immunisation Day
NIRP	National Institutional Renewal Programme
NPA	National Plan of Action
NPC	National Population Council
NPP	New Patriotic Party
ODA	Overseas Development Assistance
ODS	Ozone Depleting Substances
PAMSCAD	Programme of Actions to Mitigate the Social Cost of Adjustment
PCP	Peoples Convention Party
PEF	Private Enterprise Foundation
PHC	Primary Health Care
PNC	Peoples National Congress
PPA	Participatory Poverty Assessment
PSRP	Public Sector Reform Programme

Preface

As part of the work of the Sub-group on Programming of the Joint Consultative Group on Policy (JCGP), it was decided to undertake a Common Country Assessment (CCA) in Ghana. This proposal was based on the preliminary work in data collection that had already been initiated by UNDP, UNICEF, UNFPA and WFP, as members of the local JCGP in mid 1996. To support the development of the CCA, a team of UN staff members from the headquarters offices of UNDP, UNICEF and UNFPA visited Ghana from 17-28 February 1997.

The objective of the exercise was to correlate available information on selected indicators to the primary international summits related to social development, interpret them through joint assessment and outline trends. The core of the CCA exercise in Ghana which follows has been the assessment itself which has helped to reach a consensus on trends and challenges. The exercise had also been extremely useful in identifying the data gaps which exist. The results of the CCA are expected to contribute to Governments' monitoring of its achievements towards international goals and plans of action, and the use of UN resources towards those ends.

It is understood that following the assessment, each JCGP member agency would continue to use its own mandate and normal procedures for identifying the appropriate mix of strategies to develop and implement their country level programme activities.

CHAPTER I General Background

Political and socio-economic changes affecting social development in Ghana

Political Developments: For the first time in Ghana's 40 years of independence and four republics a parliament completed its term and stood for reelection. On December 7th 1996, Presidential and legislative elections were held throughout the country. President J.J. Rawlings, the leader of the National Democratic Congress (NDC) was returned to office for a second and final term with 57.4 per cent of the vote. In the parliamentary elections, the ruling NDC party also emerged with a sizeable majority winning 133 of the 200 seats. The New Patriotic Party (NPP) won 60 while their partners in the opposition Great Alliance, the Peoples Convention Party (PCP), won 5 seats, the Peoples National Congress (PNC) one, with the remaining seat going to an independent candidate.

A new constitution, based on the US model, was approved by a referendum in April 1992 before the Fourth Republic was established by Presidential and legislative elections in late 1992, the first since 1979. The constitution vests executive power in a president whose tenure is limited to two four-year terms. The cabinet is appointed by the president, upon approval by the legislature, a single chamber parliament of a minimum of 140 MPs elected on a first past the post basis. Candidates can be fielded by parties or stand as independents.

Since the ending of military rule, there have been positive developments in the area of good governance and civil society. There is an extremely outspoken opposition press, the go-ahead has been granted for private TV stations while independent radio stations are already in existence. Furthermore, the Commission on Human Rights and Administrative Justice (CHRAJ) tribunal set up under the 1992 Constitution has, among other things, investigated allegations of corruption and the misappropriation of funds by government officials.

The government has also begun the process of decentralisation to the 10 Regions and 110 District Assemblies. Five per cent of GDP is given over to the District Assemblies Common Fund (DACF).

Macroeconomic Situation

Table 1 Recent Economic Trends in Ghana

	1991	1992	1993	1994	1995
Real GDP Growth %	5.2	3.6	4.8	3.8	4.5
Consumer Price Inflation %	17.3	10.9	25	24.9	59.6
Trade Balance \$m	-251	-375	-558	-264	-182
Total External Debt \$m	4,351	4477	4835	5389	5750
Total External Debt/GNP %	63.3	68.4	81	101.5	
External Debt-service Ratio	27.3	28.4	24.7	24.6	25
Net ODA \$m	1331	949	930	878	

Since 1983, when the Economic Recovery Programme (ERP) was introduced, the Government of Ghana (GoG) has embarked on a Structural Adjustment Programme (SAP) aimed at accelerating growth in the economy. The reform programme has succeeded in reversing the economy's decline, with GDP growing by over 50 per cent between 1983 and 1993, having contracted by 14 per cent in the period 1973-1983.

However, the more recent years of this decade have seen a continued and increasing mismatch between stated macroeconomic objectives and actual outcomes and Table 1 clearly shows a more uneven growth record.

Some commentators have traced the economic downturn in the economy to political expediency on behalf of the government as a result of Ghana's return to multiparty democracy in 1992. Large public sector pay increases in advance of the 1992 elections turned five years of surplus into a large deficit that was inflationary and created a domestic debt that has proved difficult to clear in subsequent years. Political pressures are also seen as having led to a slowdown in the pace of divestiture.

The recovery since 1983 has been most obvious in the export sectors - mining output has more than quadrupled since the mid 1980's and cocoa output has also recovered strongly. However, agriculture, the mainstay of the economy contributing 40-45 per cent of GDP, remains very sluggish averaging just 2 per cent growth per annum during the last six-year period. The services sector has grown substantially to 49 % in 1995 but manufacturing (excluding mining) has stagnated at around 8 per cent. These wide fluctuations in the overall GDP growth rate and extensive divergences in sectoral growth rates suggest structural weaknesses, which if not reversed, may have dire consequences for the future.

The annual rate of inflation has risen from a low of 10 per cent in 1992 to 59.5 per cent in 1995 before falling to 33 per cent in 1996. The fall was due in no small part to a sizeable early harvest in 1996. Of course inflation (and agricultural growth) is often at the whim of weather vagaries. Interest rates have increased from 20 per cent in 1991 to 50 per cent in 1996, with an inordinately large, and increasing, spread between lending and deposit rates.

Notwithstanding the strengthening of the primary export base and increased diversification into non-traditional exports in recent years, Ghana's trade profile remains classically that of a poor developing country: a yawning trade deficit and dependence on a few primary products - gold, cocoa and timber.

An example of the high levels of donor-dependency of the economy is given by Donor Community contribution to recurrent expenditure (20 per cent) and development expenditure (70-90 per cent) over the last six years. The implications for sustainability of programmes are as obvious as they are a cause for real concern.

Another disquieting trend for observers of Ghana's economic performance is the failure of private sector investment to pick up despite macroeconomic growth. The importance of the private sector to Ghana's development path can hardly be overemphasised. Ghana Vision 2020 envisages private sector investment to be 11 per cent of GDP whereas it was just 6 per cent in 1995. Again, the implications of

this shortfall, coupled with donor fatigue and cutbacks in public sector investment, are obvious for the long term prospects of the economy.

The preceding conditions have (a) negatively affected the private sector and worsened the unemployment situation; (b) caused a rapid deterioration in the foreign-exchange value of the Ghanaian currency, the cedi; and, (c) pushed up the prices of food and consumer items. These inimical developments have contributed to the erosion of the pre-1992 gains in general welfare, with deleterious effects on all sections of society, especially the poor.

CHAPTER 2 Analysis of the Trends

Childhood Mortality

Data from the 1993 Ghana Demographic Health Survey (GDHS) shows a fall of 21 per cent for infant mortality from 84 deaths per 1,000 in 1988 to 66 deaths per 1,000 in 1993. Under-five mortality has also shown a 20 per cent decline from 148 deaths per 1,000 in 1988 to 119 per 1,000 in 1993.

The Infant, Child and Maternal Mortality Study (ICMMS) conducted in 1992 estimates that infant mortality fell from 104 deaths per 1,000 in 1988 to 82 per 1,000 in 1992 (a fall of 21 per cent) whilst under-five mortality fell from 172 deaths per 1,000 to 132 deaths per 1,000 (or 23 per cent) over the same years.

Assessment:

Though the different methodologies in the ICMMS and the GDHS give rise to contesting IMR and U5MR, the general trend is a significant decline in both childhood mortality rates. Despite this decline, these rates far exceed the targets of 50 per 1,000 live births for infant mortality and 70 per 1,000 live births for under-five mortality, set for Ghana at the 1990 World Summit for Children.

Most of these infant deaths have been attributed to malaria, measles, tetanus, diarrhoea, low birth weight, acute respiratory infections and malnutrition. Efforts and resources should continue to be directed at interventions that would significantly reduce childhood morbidity and mortality from these diseases.

Maternal Mortality

The ICMMS survey of 1992 reports that there are 214 maternal deaths per 100,000 live-births in Ghana. Further analysis of the data from the survey indicates that considerable regional differences exist. For example, rates between 500 and 800 per 100,000 live births have been obtained from the northern regions of the country.

Revised estimates as a result of a two-year study undertaken jointly by the World Health Organisation (WHO) and UNICEF indicate that the maternal mortality rate (MMR) in Ghana is 740/100,000 live-births. The differences between the national MMR and the revised estimate can be explained by the adjustments which have been made to compensate for under reporting and misclassification of maternal deaths.

Assessment:

Whether one looks at the new estimate of 740/100,000 live-births or the national MMR of 214/100,000 live-births, the conclusion is the same; the figures are unacceptable and maternal deaths represent a major health crisis in Ghana. Cognisant of the seriousness and magnitude of maternal deaths, Ghana with funding from UNICEF, UNFPA and USAID, was one of the first developing countries to respond to the Safe Motherhood Initiative (SMI) with the development of Safe Motherhood Clinical Protocols to promote quality service delivery in the context of Primary Health Care (PHC). By 1994, the Ministry of Health (MOH) had trained more than 6,000 Traditional Birth Attendants (TBAs) but since TBA training alone did not reduce maternal mortality significantly, the focus was shifted to emergency obstetric medical care (EmOC).

With the recognition of the important role of midwives, the MOH in collaboration with the Ghana Registered Midwives' Association (GRMA) and international donors started Life Saving Skills (LSS) training for midwives in 1991.

Emergency obstetric care is now a high priority in Ghana's maternal health and safe motherhood programme. With the development of safe motherhood education guidelines to raise public awareness and enlist community involvement in safe motherhood activities, continued LSS training for midwives and a continued investment in emergency obstetric care, Ghana should hope to see a significant reduction in maternal deaths in the not too distant future.

Childhood Malnutrition

Figure 3 compares the 1988 and 1993 levels of stunting, wasting and underweight among children age 3 to 35 months, using comparable age group for both surveys. The data shows that there has been slight increases in the prevalence of stunting and underweight and that the prevalence of wasting has increased by one-half since 1988.

Assessment:

Wasting, or acute undernutrition, reflects a recent shortage in available nutrients due to either illness or to insufficient food intake. Data from the 1993 GDHS indicates that diarrhoea was half as prevalent amongst children under three years of age than it had been in 1988. Therefore the increase in wasting between the two periods only be explained by other factors. Further investigation is necessary and the need for timely and reliable information on individual and household level food consumption patterns cannot be overemphasised. Immunisation

Data from the Disease Control Unit of the MOH shows that in 1996, 65 percent of the infant population (0-11 months) were vaccinated with BCG whilst 51 percent were vaccinated against DPT3 and OPV3. 53 percent of infants had received their vaccination for measles before their first birthday. These rates represent a 30 percent increase for BCG coverage, a 33 percent increase in coverage for DPT3 and OPV3, and a 25 percent increase for measles immunisation, since 1987.

Assessment:

These figures show a dramatic increase in immunisation coverage rates since 1987. The rise in coverage from 1989 to 1990 is attributed to the MOH's push to achieve the Universal Child Immunisation (UCI) goals with the support of WHO, UNICEF and others.

The subsequent drop in coverage rates after 1990 was because the Government was unable to sustain the momentum and thrust of the campaign. Since 1992 coverage rates for all six antigens have begun to show a slow but steady improvement. Ghana will continue to need more substantive resources and assistance in a sustainable manner to achieve 90 percent immunisation coverage rates and disease control objectives of the WSC.

Eradication of Polio

The trend graph in Figure 5 indicates an outbreak of polio every two to four years since 1984. There was a significant drop in the annual number of reported polio cases from almost 200 cases in 1985 to just 60 cases in 1988. Following another outbreak in 1989 in which there were over 100 reported cases, the number of reported cases of poliomyelitis fell to record low levels in 1992. Recent data shows that the number of reported cases has begun to rise and that cases almost doubled from 19 reported cases in 1993 to 36 reported cases in 1995.

Assessment:

The dramatic reduction in the number of reported polio cases between 1984 and 1995 is due to an increase in immunisation coverage rates for polio and partially due to the UCI campaign in 1990. The recent increase in the number of reported cases may be explained by an improved surveillance and reporting system for polio. Recent data just coming in from the MOH indicates a 96 percent coverage rate during the National Polio Immunisation days (December 1996 and January 1997). It is expected that these high coverage rates for polio immunisation will contribute to the global eradication of polio in Ghana.

Elimination of neonatal tetanus

Neonatal tetanus cases have shown a dramatic increase from 9 cases in 1993 to 216 cases in 1995 (Figure 6).

Assessment:

The rise in the neonatal tetanus cases can be explained partially by an improved reporting system by the MOH. Prior to 1993, there was no separate reporting system for neonatal tetanus. Immunisation coverage figures for the same period show that the percent of pregnant women immunised against tetanus is surprisingly small, as low as 11 percent for 1994. As part of its drive to eliminate neonatal tetanus, the MOH plans to immunise not only pregnant women but all women of child-bearing age against tetanus. This is to ensure that all women of childbearing age receive the five tetanus injections recommended by WHO to provide lifelong protection.

Reduction in measles

Figure 7 presents the trend in measles cases in Ghana since 1984. The data suggests that outbreaks of measles occur every 2-3 years. The number of reported cases fell from over 30,000 cases in 1990 to just over 17,000 in 1991. Following another epidemic in 1992 in which 39,933 cases were reported, there has been a marginal drop in the number of reported measles cases.

Assessment:

As expected the trend in the annual number of measles cases is consistent with the measles epidemic cycle, with a peak in incidence of measles occurring during an epidemic. With a continued focus on the Expanded Programme on Immunisation (EPI), a better surveillance and reporting system within the MOH, Ghana might indeed be able to significantly reduce the number of measles cases by the year 2000, as a major step to eliminating the disease in the long run.

HIV/AIDS

HIV prevalence data from blood donor and antenatal clinics show that approximately 440,000, or four percent of the adult population are HIV positive, a two percent increase over the 1992 rate. It is also projected that by the year 2000 about 760,000 or seven percent of adult Ghanaians will be infected with the HIV virus.

Current statistics from the National AIDS Control Programme (NACP) indicate that between March 1986 and June 1996, a cumulative total of nearly 19,000 AIDS cases have been reported in Ghana. The figures show some very disturbing trends. Of the 18,730 cases reported up to June 1996, 67 percent (12,483) were women, 74 percent of them between the ages of 20 and 39. (Figure 8)

A geographical analysis of HIV/AIDS in Ghana shows that there are stark regional disparities within the country. For example, over 68 percent of all reported cases come from just three regions, Ashanti Region, Eastern Region and Greater Accra Region.

Assessment:

As a follow up to the HIV sentinel surveillance carried out using pregnant women attending antenatal clinics, the NACP is in the process of setting up a wider programme of anonymous HIV sentinel sites to get more up-to-date and accurate figures which should allow for more productive planning.

Unfortunately, the reported cases do not even represent the true extent of the epidemic. It is further estimated that, at best, officially reported cases represent only 50 percent of all AIDS cases, and that more than 40,000 cases have actually occurred.

HIV/AIDS is rapidly becoming one of the most serious health problems in Ghana and is threatening to erase all gains made in maternal and child health. Initially, the HIV/AIDS prevention activities in Ghana were focused in the MOH as the pandemic was seen as a medical problem. In the programme currently being developed by NACP there is a much stronger role for other sectors and NGOs in health and non-health activities. The public information campaigns that have been organised until now have primarily focused on the print and mass media, combined with some training of counselors. The various campaigns have increased the levels of knowledge and awareness of HIV/AIDS among the general public. Recent assessment shows that most people have a basic understanding of HIV/AIDS. However, this has not led to significant behavioral change in sexual practices. Misconceptions still exist, as does considerable fear and prejudice towards people with AIDS. The AIDS problem is now understood to be a social one, with the result that Government and NGOs are

putting more emphasis on community-level projects.

Breast-feeding Initiative

Data from the 1995 Multiple Indicator Cluster Survey (MICS) shows that only nineteen percent of infants under four months of age are exclusively breast-fed. Although rather low, this rate is almost ten times the 1988 level of exclusive breast-feeding, which was 2 percent.

In Ghana, 63 percent of infants six to nine months of age were given breastmilk and complementary solid foods. This rate represents a twenty-seven percent increase over the rate for 1988. The data also shows that almost fifty percent of all children under the age of two are continuing to breast-feed. However, this percentage represents a slight decrease in the rate of continued breast-feeding from 1993.

Assessment:

Undernutrition in infants in Ghana has resulted from the reduction in the duration of breast-feeding as well as the increasing use of food supplements by mothers. As part of its efforts to improve the situation, the MOH has intensified the training of health workers in lactation management. Maternal and Child Health/Family Planning (MCH/FP) centres have also embarked on comprehensive educational campaigns to encourage mothers to increase the duration of exclusive breast-feeding from four to six months.

The Ministry in collaboration with UNICEF has also begun redesignating all health institutions as "Baby Friendly". To date there are three designated "Baby Friendly" hospitals in Ghana.

Access to safe drinking water and sanitation

The percentage of the population with access to potable water has increased from 49 percent in 1990 to 65 percent in 1995. Service coverage for urban areas showed a slight decline from 93 percent in 1991 to 76 percent in 1992 but has since risen to 88 percent in 1995. Similarly coverage for the rural areas has risen from 35 percent in 1991 to 52 percent in 1995 (Figure 10).

Figure 10 shows the percentage of the population with access to sanitary means of excreta disposal. Current levels of coverage show that there has been a marginal increase in the percentage of the total population with access to sanitation; 27 percent in 1990 to 32 percent in 1995. A breakdown by location shows that by 1995, the percent of the urban population with access to sanitary means of disposal had increased by 11 percent from 64 percent in 1991 whilst the rural rate had increased by 14 percent in 1992 to 25 percent.

Assessment:

At first glance it might seem that the increase in access to both water and sanitation indicates a positive trend and indeed, the overall picture could be viewed as positive development in the area of a high population growth. However, when looked at in terms of the World Summit for Children (WSC) goals of universal access, it seems rather unlikely that Ghana will achieve its goal. If the WSC goals of universal access are to be realised then efforts should be accelerated and intensified. It is hoped that the ongoing structural and decentralised water and sanitation programme within the Ghana Water and Sanitation Programme will form the basis for an accelerated growth and increase in service coverage to all areas.

Guineaworm Eradication

Data from the Ghana Guineaworm Eradication Programme (GWEP) shows that the annual number of cases of guineaworm has shown a dramatic decline from approximately 180,000 cases in 1989 to just over 8,000 cases in 1995. However, there was a slight increase in the number of cases from 1994 (7,104) to 1995 (8894).

A recent report from the GWEP shows that from January to November 1996, the number of reported cases of guineaworm was 4378. The number of villages with any case of guineaworm disease has also dropped from over 3000 in 1992 to just under 2000 in 1995.

Assessment:

Further analysis of the data by region shows that majority of the cases are from the Northern Region. A probable explanation is that the activities of the GWEP were disrupted by the ethnic conflict in the Northern Region in 1994-1995.

Research has shown that, in general, the rates of case containment of guinea worm correlate well with the extent of reduction of cases. i.e. the higher the percentage of cases contained, the greater the impact on incidence of dracunculiasis.

With the realisation and commencement of case containment in the Ghana's GWEP in 1994, it is expected that Ghana will realise its goal of elimination of guineaworm disease by the year 2000.

Education

Figure 12 shows that the eight percent gain in primary school net enrolment rate over the 1988-92 period was not maintained, but was followed, over the subsequent three-year period (1992-1995) by a three percent drop (assuming data reliability between the two sources—GLSS (1988, 1992) and MICS 1995).

Assessment:

This negative trend could be attributed to the introduction in 1992 of the Structural Adjustment Programme (SAP) cost recovery/sharing measures, resulting in higher school costs to parents/guardians. A study conducted by the Ministry of Education (MOE) and UNICEF in the same year appears to confirm this, as it identifies costs of schooling as the most significant factor behind non-enrolment and dropout. The apparent narrowing of the gender gap in the net enrolment ratio over 1992-95, would have been more welcome if it had been the result of an increase in the net enrolment ratio for girls, rather than the consequence of a larger drop for boys (7 percent) compared to that for girls (3 percent). Again, the SAP and the consequent economic hardships appear to be behind this, with more boys (presumably)

feeling the pressure (both internal and external) to drop out of school to pursue income activities .
This led the group to question the validity of the extent of poverty reduction.

Adult literacy

Available data in the country reveal that the adult literacy rate for females is lower than that of males (38.5 percent to 60.8 percent in 1992).

Assessment:

Recognising this disparity, the GoG through the MOE has embarked upon an Educational Reform Programme (ERP) aimed at:-
strengthening the institutional infrastructure for promoting literacy;
emphasising practical and vocational components of the school curriculum;
improving supervision and management in schools as well as instituting community-based programmes for early childhood development;
enhancing equity through expansion of schooling to under-served areas and groups and improving patterns of girls' attendance in schools.

Iodine Deficiency Disorders

In 1993, the proportion of primary school children with any signs of goitre was ten percent. The MICS survey conducted by the MOH in 1995 indicated that only 0.3 percent of households surveyed were consuming iodised salt.

Assessment:

The Act of Parliament making it mandatory to iodate all salt for human and animal consumption received presidential assent and was published and dated 31 December, 1996. From the 1st of July 1997 there will be full enforcement of the Act including the arrest and prosecution of offenders.

A reduction of prevalence of goitre and a significant increase in the proportion of the population consuming adequately iodised salt is anticipated.

Reproductive Health/Family Planning

The 1993 GDHS results indicate an overall total fertility rate of 5.5. The corresponding figure for the 1988 survey was 6.4, representing a drop in fertility of approximately one child per woman. The age-specific fertility rate for women 15-19 years of age was shown to be 119 per 1000 women representing a decline from the 1988 figure of 124 per 1000 women.

The 1993 GDHS also reports that the percentage of all women and currently married women who are aware of family planning methods is 90 per cent while utilisation of modern contraceptive methods is only 10.1 per cent.

Assessment:

In order to bridge the gap between knowledge, attitude and practice (KAP) and further reduce fertility rates, information, education and communication (IEC) interventions are being repackaged to promote better services and behavioural changes. Couples and individuals will be empowered to make informed decisions and choices about the number and spacing of their children through the use of modern contraceptive methods. In this connection, the National Population Council (NPC) with support from UNFPA and USAID have begun to develop a national strategy to reinvigorate IEC and counseling activities.

Poverty Eradication

The data shows that between 1988 and 1992 there was a slight decrease in national, rural and urban poverty levels. Approximately 75 per cent of the national poverty can be attributed to rural areas. However, the poverty differential between the rural and urban areas has narrowed from 14.5 per cent in 1988 to 7.4 per cent in 1992 (figure 16).

Assessment:

The effects of poverty on the education and health of families in Ghana are striking. The net primary school enrolment rates for poor boys and girls are 77 per cent and 72 per cent respectively, while the rates for non-poor Accra children are 97 and 91 per cent respectively. Although poverty clearly reduces the likelihood of school attendance, region of residence appears to be as important, as evidenced by the low net enrollment rates of 59 per cent for boys and 46 percent for girls of non-poor families in the Savannah. Similar considerations apply to secondary enrollments. Whereas the net secondary enrollment rate is estimated to be 31 percent for the female children of poor Accra residents, it is just 22 per cent for girls in non-poor households in Savannah. The GLSS3 data confirm a marked gender bias in school enrollments, especially at the secondary level. This appears to be aggravated by poverty with the gender differentials in enrollment rates being more marked in poor households.

An important demographic feature of poverty in Ghana is the gender dimension. Unfortunately, with the GLSS data, it is not possible to distinguish between poverty and welfare between men and women, since expenditures are defined only at the household level. One approximation to the gender dimension of poverty is to separate female- from male-headed households.

The GLSS3 reports a lower incidence of poverty among female-headed households (28.5 %) than their male counterparts (33.2%) but there are two problems with this conclusion. Firstly, the data does not distinguish between *de jure* and *de facto* headship. Households reporting a female head but in receipt of significant remittance income are unlikely to be *de facto* female headed, with the absent spouse

providing for the needs of household members. According to GLSS3 estimates, over fourteen per cent of the income gained by female-headed households was derived from remittance flows in 1992 compared with just three per cent in male-headed households.

Secondly, since the GLSS uses per capita expenditure as the welfare measure and female-headed households tend to be much smaller than male-headed households, this results in lower poverty incidence among them. Once household size is controlled for, female headship implies higher poverty - i.e. female headed households tend to exhibit higher poverty than households of similar size headed by males. These conclusions are more consistent with the qualitative evidence of the Participatory Poverty Assessments (PPA), commissioned by UNICEF Ghana in 1995. The PPA suggested that female headship was closely linked to poverty, especially in the north of the country, and when it is combined with widowhood, old-age and the absence of adult children.

The GLSS3 data, a snapshot of poverty levels existing in 1992, only became available in published form during 1995. This delay, together with the widespread view that poverty levels had increased throughout Ghana (and especially in urban areas) since 1992, led to disquiet being voiced in the Donor Community (DC) about the need for an up-to-date and ongoing monitoring and evaluation system for measuring poverty in Ghana. It was also felt that the use of arbitrary poverty lines (i.e. calling those below two-thirds of the mean expenditure per household poor) did not completely capture the complexity and multi dimensionality of poverty and that a more embracing measure including access to health, education and nutrition could be employed.

The Convention on the Rights of the Child

Ghana was the first country to ratify the CRC in February 1990. After the ratification of the CRC, the Ghana National Commission on Children (GNCC) became the main coordinating body, both for publicising the Convention, as well as the processes needed to give effect to the provisions of the Convention.

Definition of the Child

Article 28 of the 1992 Constitution defines a child as person under 18 years old.

Right to life, survival and development

The 1992 Constitution reinforces the child's rights to proper development by the provision that basic education shall be free, compulsory and available to all. Other measures to ensure the child's right to life and survival includes the health regulation to immunise all babies before the age of one. The promotion of exclusive breast feeding for the first four months of a baby's life is also being pursued.

Basic Health and Welfare

The MOH is the central government agency on health matters. The government policy is committed to improving the health of all people by making basic health facilities accessible to all Ghanaians. The cash and carry system introduced by the MOH about two years ago has effectively cut off potential users health facilities. Maternal and child care programmes are substantially supported by donor funding and sustaining them will become a major challenge in the future.

The Constitution guarantees the right of the disabled to special treatment. Schools for children with physical and mental handicaps are situated in various parts of the country. However they are not able to meet the special needs of all the disabled children. As a new strategy the Department of Social Welfare (DSW) operating Community Based Rehabilitation (CBR) in 20 out of 110 Districts with the assistance of UNDP and other donors. It is anticipated that CBR will be the government's main method of delivering assistance to the disabled.

Labor Laws

Child labor, does exist in the informal sector in Ghana and generally takes the form of self-employment i.e. petty trading, pottering, shoe-shining, domestic laboring. Although there are laws to protect children from the abuses of certain types of child labor, the laws are rarely enforced. Research has shown that very often child labor is due to genuine poverty within the family. There is little consensus in attitudes and practice over what constitutes abuse in terms of child labor. Efforts are being made by the GNCC and other NGOs to organise educational programmes for children who must work during school hours.

Civil Rights and freedoms

Ghana took advantage of the UN Convention to make provisions for the child in the Fourth Republican Constitution. The relevant section is Art. 28, 1-5. Art. 6.2 guarantees the nationality of any child born in or outside Ghana if either of the parents is or was a Ghanaian. The Constitution also states that "a child of not more than seven years of age found in Ghana whose parents are not known shall be presumed to be a citizen of Ghana." a child under sixteen years of age neither of whose parents is a citizen of Ghana who is adopted by a citizen of Ghana shall, by virtue of the adoption, be a citizen of Ghana. The Birth and Deaths Registration Act 1965 compels all people resident in Ghana to register the birth of all babies. However, in many rural areas registration of births is infrequent.

The Right not to be subjected to torture or other inhuman or degrading treatment or punishment

The constitution, Article 28 (3) categorically provides that no child shall be subjected to torture or other cruel inhuman or degrading treatment or punishments. There are currently laws against female circumcision and other forms of negative treatment.

Family Environment and Alternative Care

The DSW provides welfare services to children in cases of child neglect, child abuse, juvenile delinquency, child abandonment, adoption, child custody etc. The DSW currently operates 3 homes in Ghana for 100 children. Usually the homes provide short term care for very young children whose mothers have died in child birth, or been imprisoned or abandoned. These children are either returned to their families or placed for adoption according to legislation. There are four other homes operated by NGOs and regulated by the DSW.

Special protection measures

Reports of child sexual molestation is on the increase. The International Journalists for Children's Rights (ICJCR) have protested

that the minimum sentence of three years passed by Parliament recently is too low a punishment to be an effective deterrent.

CHAPTER 3 Cross Cutting Issues

INTRODUCTION

The concept of sustainable development implies balancing environmental concerns with the generation of increased opportunities for employment and improved livelihoods. It is clear from this definition that in order to achieve sustainable development, governments will need to develop policies as well as implement interventions that will reflect the interactive processes that affect the use of land, water, air, energy and other resources. Human dimensions are also key elements in this intricate set of relationships need to be considered.

As indicated in the Country Strategy Note (CSN) for Ghana, the objectives of the country's medium term development plan is to consolidate the gains achieved under the Government's ERP and SAP and strengthen the foundations for accelerated economic growth. Furthermore, the plan is aimed at improving the social and economic well-being of Ghanaians and to alleviate poverty and deprivation through the promotion of creativity, enterprise and productivity of all Ghanaians. In furtherance of these developmental objectives, the UN system organisations in Ghana have embarked on this common country assessment in consonance with the circular issued by the five executive heads of the JCGP on 27 December 1995 in order to adopt a multi-sectoral and inclusive approach towards influencing the country's sustainable development policies and trends. It will also enhance the harmonisation and coordination of procedures as well as strengthen collaboration between the UN system organisations in Ghana.

In order to facilitate joint programming among members of the JCGP in Ghana, five broad cross-cutting issues have been identified to guide the activities of the group. These are: (i) environment; (ii) gender considerations; (iii) basic services; (iv) non-governmental organisations (NGOs) and civic society; and (v) capacity building. The JCGP group is represented in Ghana by UNDP, UNFPA, UNICEF and WFP. Their activities cut across various elements of the socio-economic plan of the country. Below are some of the activities in the areas outlined above:

Environment

As an integral part of the overall process of development, the environment encompasses the relationship and interdependencies that exist between human populations and their natural resources. Environmental changes are therefore a product not only of natural events but also of the application of development paradigms, practices and life styles. Any modification of the physical environment has important socio-economic consequences that affect the quality of life of human beings. It is also widely acknowledged that the links between poverty, high population growth and environmental degradation are mutually reinforcing. Thus, investing in people by reducing poverty and population growth is a moral imperative and essential in the long run for arresting environmental degradation. Agenda 21 adopted at the UN Conference on Environment and Development (UNCED) in 1992 also places emphasis on the role of women on sustainable development. Since then many other conferences and fora have encouraged joint initiatives among international, regional and bilateral organisations for engaging women in ecosystem management at the grassroots level.

Given a growing concern for environmental issues, the Government of Ghana (GoG) has initiated the preparation of a National Environmental Policy Statement and a National Environmental Action Plan (EAP). The EAP places emphasis on the nexus between rapid population growth, agricultural development and resource depletion notably losses in soil fertility and forest cover.

The UN organisations in Ghana have assisted government to promote environmental management. Some of the activities of these agencies are direct while others have been catalytic in effecting changes in policies and interventions. For example, the UNDP through its Fifth Country Programme has provided assistance to Government to facilitate the integration of environmental issues in national development efforts. Specifically the UNDP has: (a) supported the establishment of an Agro-forestry Unit within the Ministry of Agriculture (MOA); (b) the establishment of a focal point for desertification control within the Environmental Protection Agency (EPA); and (c) the preparation of an Action Plan to phase out the use of ozone depleting substances (ODS). The UNDP has also integrated environmental concerns and natural resource management into its ongoing programmes. The WFP has provided assistance through food aid towards the improvement of the country's forest resources and game and wildlife reserves as well as for community forestry and agro-forestry schemes. Through the Food for Work programme, the WFP in collaboration with the International Fund for Agricultural Development (IFAD) has provided assistance for the rehabilitation of dams in the Upper East Region.

Gender Considerations

The UN Decade for Women (1976-1985) and the 1995 Fourth World Conference on Women have played a crucial part in highlighting and publicising the important but previously unrecognised role of women in socio-economic development. Since then policy makers and planners have made efforts to shift their focus from a universal concern with family-oriented programmes (which assumed motherhood as the most important role of women in the development process) to approaches which take into consideration the productive and reproductive roles of women.

The 1984 census of Ghana revealed that women constitute 51 percent of the country's population. The census also showed that women play a dominant role in the Ghanaian economy especially in agriculture and commerce. The 1989 Ghana Living Standard Survey showed that 91 per cent of economically active women were self-employed. The 1984 census however indicated that only 10 per cent of economically active women could be classified as professional, technical, administrative or managerial personnel. The literacy rate for women was also low. Between 1992 and 1996, of the 200 parliamentary seats, only 16 were women. This figure however increased to 18 after the 1996 general elections.

The health status of the Ghanaian woman is also relatively low. A report from the MOH shows that maternal morbidity is quite high though actual figures are not available. The maternal mortality rate is 214 per 100,000 live births though rates between 500-800 have been recorded in the northern regions of the country. Another important aspect of Ghanaian women is their fertility behaviour. The results of the 1993 GDHS indicated that the total fertility rate for women aged 15-49 is 5.5.

Following the declaration of the UN Women's Decade, the GoG established the National Council on Women and Development (NCWD) in 1975 to promote the integration of women into the developmental process. In 1986, Ghana also ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). Furthermore, in 1985 the government passed the Intestate Succession Law and Registration of Customary Marriage Law to protect the welfare and interest of women and children. Parliament also enacted a law prohibiting female genital mutilation in 1995. The government has also taken measures to ensure increase in enrolment as well as the retention of girls in school.

Within the context of the Government's policy framework, the agencies of the JCGP have supported a number of initiatives aimed at empowering women as well as enhancing their status. Significantly, all the agencies have mainstreamed gender into their respective

areas of responsibility. For example, each of the agencies has provided funds to support income generation activities of women. The UNFPA has assisted such activities as entry points for the introduction of reproductive health services. Through the Supplementary Feeding and Nutrition Education component of its programme, the WFP has assisted in improving the feeding of children and mothers in the severely food distressed areas of the country. Under the Food-for-work projects, the WFP has provided support for women's income generating activities. Under the rural community-based project, UNICEF has assisted activities to improve the income of the poor, particularly women to enable them to procure improved services including food. UNDP has also supported the development of small scale enterprises for women.

Basic Services

Though Ghana has made some significant progress in education, health and other social development areas in recent years, the progress has been uneven and serious inequalities persist both between and within regions in the country. The critical issue has been the gross mismatch between the problems in health, education etc. and public investment in these areas. The Economic Reform Programme (ERP) and the SAP, which began in 1983, have been faulted for reducing living standards, cutting off resources for vital social expenditure on health and education and thus contributing to a worsening of the status of the poor and such vulnerable groups as women and children.

In order to address the myriad of problems facing social development in many countries, the World Summit for Social Development (March 1995), the International Conference on Population and Development (ICPD) and the Platform for Action for the Beijing Conference entreated Governments to implement programmes to meet the basic needs of all citizens.

The GoG in 1987 launched the Programme of Actions to Mitigate the Social Cost of Adjustment (PAMSCAD) in order to address the needs of vulnerable groups whose conditions had been worsened due to the SAP. The government also introduced a 3-year Public Investment Programme (1988-1990) to improve the efficiency of public resource allocation and management. As part of the Programme, the government provided for the continuation of the rehabilitation and reconstruction of key economic and social infrastructure as well as for institutional building. Government has also increased its budgetary allocations for basic social services since 1990 to ensure that people living in poverty and low income communities have access to such services. For example, the government has launched a 5-year Medium-Term Health Strategy (MTHS) which will lead to the establishment of a National Health Service to promote the delivery of services. The Government has also introduced a Free Compulsory Universal Basic Educational (fCUBE) Programme to improve the quality and accessibility of education. However, rising inflation and a rapid decline in the external value of the cedi have remained critical features of the gap in the provision of services.

JCGP agencies have provided a diversity of assistance to the country to promote the quality of education, improve the quality and access to health services, promote efforts to rectify inequalities relating to social conditions and to foster people-centred sustainable development. To this end, with the adoption of the fifth Country programme in February 1993, UNDP has supported participatory development approaches for poverty alleviation. UNFPA and UNICEF have assisted in the establishment of a Safe Motherhood Programme within the MOH to promote the health of pregnant women. The two agencies have also assisted in the provision of facilities and equipment to improve the educational (formal and non-formal) and health activities of the Government. WFP has also supplemented Government's efforts in the feeding of school children as well as in the construction of school buildings.

NGOs and Civil Society

Non-governmental organisations have played a vital role in the socio-economic development of Ghana. In the health sector for example, almost half of total visits for services occur in private facilities. However, the NGO and private sector have not been given the required recognition by the Government. Furthermore, there is little government support to NGOs and there is also little linkage between public and private sector activities.

In order to rectify this trend, the Government has recently proclaimed NGOs and the private sector as the engine of growth of the Ghanaian economy and has instituted measures to strengthen the institutional capacities of NGOs and promote their involvement in investment, production and trade. Through the Divestiture Implementation Programme (DIP), the Government has divested its ownership in a number of business concerns in order to attract private and NGO ownership. Private ownership is also being boosted through the Ghana Stock Exchange. In the health sector for example, the MOH has outlined in its five-Year Programme of Work a strategy to promote partnership with the private sector to enhance the delivery of health services.

The local JCGP agencies have expanded their support for the activities of NGOs and civil society in their respective programmes. Under the third UNFPA Country Programme, nine religious institutions and four other NGOs are being assisted to progressively implement a wide range of reproductive health activities. The Fund is also assisting women NGOs to integrate reproductive health into their operations. The UNDP under the "support for efficient private sector and science and technology development" has embarked upon a comprehensive effort to strengthen capacities of NGOs such as the Private Enterprise Foundation (PEF) in support of the accelerated growth programmes of the government. Under its Social Mobilisation Programme, UNICEF is assisting to increase the capacities of various institutions and NGOs to effectively sensitise and mobilise communities to promote activities in health, HIV/AIDS, education, nutrition and EPI. In order to increase its grassroots involvement, WFP has promoted active links with a number of NGOs through the implementation of food aid projects to promote reforestation and the development of woodlots.

Capacity Building

One of the main constraints to the implementation of the Government's Accelerated Growth Programme is the inadequacy of appropriate national capacities. A new capacity-building challenge has also arisen with the launching of the government's decentralisation programme. With the establishment of District Assemblies and their sub-committees, there is the need to develop the capacities of the sub-committees as well as decentralised departments to collect and analyse social information and to take responsibility for the improvement of their communities' well-being. In tandem with the government's major policy document "Vision 2020", a Public Sector Reform Programme (PSRP) has been instituted as part of the National Institutional Renewal Programme (NIRP) which was launched by the Head of State in December 1994. The overall purpose of the NIRP is to contribute to the attainment of good governance, accelerated growth and equitable social development, private sector development and a more compact and efficient public sector.

As part of efforts to outline an outward looking strategy increasing the pace of economic growth and social development, the Government, with the support of UNDP and the World Bank commissioned a study in 1994 to assess the capacity development

requirements of the country. Following the findings of the report, UNDP has initiated a Capacity Building for Development Management Programme to strengthen the capacity of selected implementing and collaborating agencies in training, entrepreneurship, science and technology, information etc. UNDP has also supported the International Economic Relations Division (IERD) of the Ministry of Finance to strengthen their aid coordination.

Furthermore all the country programmes of the other JCGP agencies except WFP have capacity building components. For example, UNFPA continues to support the institutional strengthening of the National Population Council (NPC), the MCH/FP Unit of the MOH and other governmental and non-governmental organisations to promote the implementation of population and reproductive health activities. This support has been complemented with the improvement of skills of various categories of staff of these organisations.

UNICEF supports national institutions such as the Ministries of Health, Education, Mobilisation and the National Development Planning Commission (NDPC) to develop the capacities of these organisations to carry out analysis and formulate policies within the context of the government's decentralisation process and local capacity building and also towards the attainment of the goals of its National Plan of Action (NPA).

CHAPTER 4: Institutional Response

Introduction

In support of the CCA process, it is desirable that an institutional framework be mapped out. The framework should target the capacity of the JCGP group and other UN agencies as well as the GoG and development partners. It must be borne in mind that ultimately the common assessment is focusing on promoting joint programming and common strategies.

Accordingly, on both the UN side and that of GoG, efforts should be made to encourage relevant institutions to carry out responsibilities towards joint programming. In this direction, it should be possible through the CCA process to target relevant institutional mechanisms that would balance both capacity building and institutional excellence.

Five major areas could be addressed in building the capacity of the JCGP group in the said direction.

GOVERNMENT OF GHANA

Data Collection Mechanism

Since the Ghana Statistical Service (GSS) will assist in the creation of the capacity to expand this UN CCA database, it would be desirable to provide access them and other end-users participating in the promotion of data in favour of joint programming.

Technological Infrastructure

In the age of fast technological development, it would be appropriate to put in place a system that provides direct communication, not only to UN agencies but to relevant development partners. This calls for a level of technology like internet and the Worldwide Web Network. It should be recalled that the primary purpose of the database is to ensure the analytical trends of those problems to factored in common programming.

National Dialogue on Database Trends

The UN system as initiated by the CCA process will use the observed analytical trends to support the national dialogue. With special reference to national dialogue it is clear that the CCA report will serve as standard reference for highlighting problem areas in national development. As the database tracks the trends in the problem areas it is necessary for decision makers and planners to build in processes which address those problems. This calls for the arrangement of national workshops and seminars to discuss identified problems based on the CCA report.

Feedback into Database

As the decision makers and planners become interested in the CCA report as a reference document, the results of the national dialogue in search of reforms should be based on objective trends as reflected in the figures of CCA report. Accordingly, a systematic feedback into the database would have to be designed to ensure the reinforcement of both the trends and planning/programming experience.

The CCA Process and Country Programming

As the GoG interacts with the UN system and other development partners, the problems identified through the CCA process should be addressed in the programmes of support to Ghana. This requires that the UN agencies, GoG, and development partners work together in identifying common approaches to programming. The CCA thus encourages a common perspective in solving national problems.

UNITED NATIONS

Framework for CCA Process

Each JCGP group member should as a matter of course appoint a CCA focal point who will collaborate with the other focal points in the respective agency. If there are problems with excessive workloads a consultant may have to be used. That may be arranged on a shared basis where in-house capacity is lacking.

It may be pointed out that as the common indicators expand to include other UN agencies, it may be necessary to seek a common consultancy that would be used by all agencies when it comes to updating the enlarged database.

Ownership

Given the fact the database is currently located at UNICEF, efforts will be made to put in place structures so that data input and output is easily accessible to all Agencies as well as GoG and development partners. The best solution to the above- mentioned would be direct access through internet. Monthly and quarterly circulation of information on the development of indicators on paper or on disk format would be forwarded to UNICEF for input into the central database.

Shared Information with Development Partners

The JCGP group should set up channels where the common identified trends would be circulated to development partners. The established fora that are either thematic or sectoral based will offer an opportunity for the analytical trends from the database to be shared with GoG, with civil society and donors.

Mechanism for Programming Purposes

By institutionalising the CCA report production on a regular basis, a common structure should be formed to address and capture the

areas of programming on a common basis. That will enable the UN agencies to improve the development of common perspectives to programming.

It seems proper to put in place an annual exercise within the JCPG group to promote the CCA process along the following lines:

First Quarter:

Finalisation and Submission of CCA Report to Headquarters.

Second Quarter:

Discussion with GSS on Data Gaps and Redressing and updating data.

Meeting of Technical Working Group and delegation of tasks.

Third Quarter:

Submissions by Technical Working Group Members and Consultants of all updated information for databanking.

Fourth Quarter:

Draft CCA Report preparation.

Promoting National Dialogue

UN agencies should promote national dialogue through workshops/seminars to enable national focus on programming for tackling problems identified by the CCA process. Accordingly, the UN agencies would approach GoG as well as development partners in developing a common platform that lends itself easily to greater impact on the UN delivery.

CONCLUSION

It should be noted that on both the UN side and that of the GoG, little reference has been made to civil society. That is intentional, though it is recognised that the civil society includes private sector, the communities and their people. It is implied in this chapter that the focus is on institutional framework that will facilitate policy development through the objective analytical trends derived from the database.

In this way, the UN agencies serve as a catalyst to GoG policy development as well as facilitate relevant programming. Therefore, the CCA process serves as a vehicle for balanced policy development.

CHAPTER 5 Conclusions and Recommendations

SUMMARY OF PREVIOUS CHAPTERS

General Background

It is imperative that Ghana, though faced with serious liberalisation and democratisation challenges, matches economic growth with accompanying socio-political developments. Therefore the search for objective data to measure the problems raised by these challenges is necessary if relevant policy reforms are to be supported by relevant development programmes.

Assessment Trends

In this area it is evident that there is erosion of the social quality of life among the average Ghanaian. The spin-off as we examine the social indicators (health, education, gender, etc.) reflects poverty related problems that demand reexamination of development policies.

Cross-Cutting Themes

Of interest in this area is the emerging trends among the JCGP Agencies and their development partners e.g. private sector, public sector, NGOs, etc. not only are these development partners coming closer together in synergising their activities/sectoral concentrations but they are also beginning to plan together. The result is more efficiency in programming as well as resource utilisation.

Institutional Response

In this particular case it is clear that in order to promote the establishment of the CCA database there has to be a common perspective among the agencies in supporting the relevant arrangements. That goes with an establishment of institutional arrangement to ensure in-house capacity as well as that of supporting institutions like GS

CONCLUSIONS

The CCA exercise has essentially served to highlight Ghana's performance regarding its obligations under the terms of the declarations of the various World Summits and International Conferences since 1990. Apart from serving as a standard reference for highlighting problem areas in national development, the report, through its database, analysis and assessment, serves two complementary purposes: It shows the trends in the chosen indicators since the signing of the relevant World Summits or International Conferences and information lapses in certain crucial programming areas.

It was clear that some conferences and summits were specific on indicators and targets to be achieved while others were far more vague. In addition, the viability of filling many of the data gaps is open to question. At best the task of building capacity is an arduous, protracted one.

In general, three major trends have emerged from the indicators, viz., positive trends, showing an improvement in the indicator; negative trends, showing a deterioration of the indicator, and thirdly positive trends, but not on track with the stated targets of the conference/summit. There were also some indicators for which data was only available for one year, thereby not allowing an assessment of trends.

Positive Trends

Indicators which have shown an improvement include the eradication of polio and guinea worm disease, even though in the case of the latter, the number of villages still affected is very high.

Negative Trends

Negative trends were seen infant and under-five mortality rates, the number of reported cases of neonatal tetanus (even though the increase in numbers may be due to improved surveillance and reporting systems), childhood malnutrition, primary school net enrolment rates and HIV/AIDS prevalence.

Positive Trends but off track

Even though some indicators, such as childhood mortality and exclusive breast-feeding have shown some improvement, their rates are still considered unacceptably high, in the case of childhood mortality, or too low, in the case of exclusive breast feeding. Immunisation coverage rates have oscillated but again the improvement is not keeping pace with the stated goals. Interestingly, though the improvement in access to safe drinking water and sanitation was seen as satisfactory under the Rio goals, the rate of progress was considered too slow in the light of the WSC goal of universal access by the year 2000.

During the assessment, certain methodological problems arose. The revised estimate of maternal mortality does not as yet allow comparative trends though it is clear that the rate remains unacceptably high and maternal death remains a major health concern. Secondly, due to different methodologies, two separate studies showed different rates for infant and child mortality though the decline was broadly consistent. Thirdly, the analysis for childhood malnutrition takes into account the different methodologies in the two studies (GDHS 1988 and 1993) and assesses the prevalence of wasting, stunting and underweight for comparable age groups. Finally, inconsistencies in rural and urban poverty figures were discovered between the World Development Reports and figures calculated by the group from the GLSS reports.

In the area of family planning, there is an urgent need to move from awareness of contraceptive methods to use of these methods. Currently, only 10 per cent of all women use modern contraception whilst 97 per cent are aware of modern contraceptive methods. When compared to other developing countries, the GDHS 1993 figure of 1.8 per cent for low birth weight infants seems suspiciously low and requires further investigation.

The reduction in the number of people living in poverty in Ghana from 41.8 percent in 1989 to 31.4 percent in 1992 seemed to be in conflict with certain poverty-related indicators - especially the increased prevalence of childhood malnutrition and the decline in the primary school net enrolment rate.

It was also felt that there was an pressing need to update the poverty figures and that the more recent proxy indicators may point to a rise in poverty levels.

Substantial data gaps exist especially with regard to those indicators related to the Beijing Conference on Women, the Rio Summit and the CRC. On the other hand, as the WFS was held in November 1996, it is too early to assess its impact on the situation in Ghana. Nevertheless, the absence of reliable data on household incomes and household food production makes any assessment of the situation difficult.

The assessment exercise has brought into a sharp focus the need for closer collaboration at the technical level among the JCGP agencies. The exercise demonstrated the need for the agencies to work together to identify common approaches to programming. This is more so given that the agencies whilst, working independent of each other, are all involved in several crosscutting themes such as the environment, gender considerations, provision of basic services and on relations with NGOs and civil society. Therefore, there is a need to harmonise all these independent actions into a common approach to programming.

RECOMMENDATIONS

There is a need for continued GoG interaction with the UN system and other development partners to address some of the problems identified in the CCA process through the agencies programmes of support to the country. It is recognised that the Ghana Statistical Service (GSS) is the mandated national institution responsible for the collection and storage of data. Therefore it would be logical for the JCGP to liaise with the GSS to ensure that the data gaps existing in the CCA database and other identified data inadequacies (mostly with regard to data consistency and disaggregated data by region, sex and age-groups) be addressed. In that direction it is recommended that the JCGP members in Ghana consider technical assistance to GSS to ensure institutionalisation of the linkages with the CCA database.

Specifically on the CCA process it is recognised that to support the common platform for objective analysis development problems, the JCGP Agencies need to systematically develop a common CCA database. Indeed, efforts to harmonise various figures from different sources were made during the assessment. A database of core common indicators should create the framework which will lead to jointly analysing policy instruments and addressing targeted development problems.

Though little interaction took place between the JCGP Agencies and the GoG in the preparation of the document, continued collaboration dialogue is required between GoG, the UN agencies and other development partners to identify common approaches to programming.

Efforts must be made by the agencies to speed up data storage and retrieval by all parties including the UN agencies, the GoG and other development partners. Related to this is the need to establish information dissemination mechanisms to enable information on the identified trends reach all end users on a regular and timely basis.

The CCA exercise should be shared with, and ultimately include, all technical UN agencies in the country.

**Appendix 1:
Terms of Reference for the Common Country Assessment Mission to Ghana**

The copy of the agenda adopted by and discussed by the JCGP participants in New York constitute Appendix 1.

Participants concluded discussions on items on the agenda as follows:

1. Minutes of previous meeting

Decision

UNFPA which was holding the Chair at the time of the meeting should finalise the minute for the previous meeting.

Actions

- a) Each Agency Representative will forward its comments to UNFPA.
- b) For future meetings, UNICEF will prepare the minutes. C. Mbengue provides Secretariat support for JCGP within UNICEF. She will share draft with members for comments.

2. Workplan /Common Country Assessment

Decisions

A) An Inter-Agency team from HQs will visit Ghana and work on the Country CCA

- a) The Sub-Group accepted, in principle, that Agencies' Representatives visit Ghana for 2 weeks in February to work with the Ghana team. The purpose of the exercise is to support development of a Ghana CCA and to prepare a paper on the process. During the exercise JCGP members will bring together information, related primarily to the international Summits, interpret them and outline trends. Other agencies will be encouraged to participate with the idea to expand the Group beyond JCGP's. Ghana was chosen because of preliminary work already done by the country team and the enthusiasm manifests by the country to be a "test case".

Action members will report back to the Sub Group on the participation of their Agency. Those who cannot stay in Ghana for two weeks could participate during the beginning of the exercise. Each Agency will inform its Office in Ghana about the mission

- b) One result of the Ghana exercise will be draft guidelines of CCA.

Ghana exercise is important a first step in an evolving process. It is an opportunity to show a concrete example of a field-based/driven process towards CCA guidelines. Subsequently, a range of other countries, either with CCA experience or selected for a trial, will follow. These countries will collectively constitute a fair variety and spectrum of experiences to facilitate preparation of guidelines which are representative at global level.

B) Preparation of an outline Workplan indicating milestones leading to final CCA Guidelines.

The group agreed to prepare an outline of a Workplan indicating steps foreseen at this stage for the preparation of the CCA Guidelines. This Workplan and the results of the Ghana exercise will be reported to the March General Meeting.

Action

Mr. B. O' Brien will prepare a draft of outline of the workplan. This will be shared with members together with the minutes of the meeting.

- C) **Openness of Indicators** Agencies could visit and review indicators. In preparation for the Ghana mission, JCGP Technical Advisors on indicators will meet to discuss the framework for indicators before 13 of February.

Action

Mr. Gareth Jones in UNICEF will call the meeting.

- D) **The Sub Group will seek to ensure good communication with other Inter-agency Committees and Initiatives.** This is an effective strategy to stimulate collaboration of other agencies at country level and to increase understanding on the work of the Sub Group. The Sub-Group will explore mechanisms that will enhance this communication, while keeping to the pace of the workplan: consultation with individuals working on specific themes (Human Development report); briefing of other inter-agency committees (e.g. the Working -Group on Resident Coordinators).

3. Monitoring of Harmonization of Programme cycle

Decision

The Sub- Group will first take stock of decisions taken in the past on this item.

Action

Mr M. Hyder will provide members with relevant information on previous decisions prior to further discussion on this item.

- 4.1 **Secretary General's letter of 29 January to Head of Department, Fund and Programme on "Policy coordination**

Group”

Decision:

The Sub- Group wants to explore possible responses to this letter’s concerns.

Action

The Chairperson will call an ad- hoc meeting to discuss this item

CCA Workplan

JCGP Technical Advisors on indicators meet to discuss framework for indicators before 13th. February.

JCGP Team travels to Ghana to participate in CCA process with country team for the period 17-28 February 1997. Each agency will decide which staff resource it wishes to utilise in Ghana. The output will be a CCA document that reflects the assessment process based on information available in relation to the main interests of the participating agencies. A second output will be a document that describes the process used to carry out the CCA.

During the period 2-15 March the JCGP CCA for Ghana will be circulated among participating agencies and the process document will be configured into a DRAFT guideline on how the exercise was carried out.

The Harmonisation Sub-Group will meet again early March to review progress and review list of additional countries that could be supported between April and September. It is expected that at least three additional countries will be included in similar exercises in order to expand the experience.

The Ghana CCA will be circulated to the April General Meeting of JCGP.

Each country will produce a CCA product and a process document. After each of these CCA exercises the DRAFT guideline will be updated.

A seminar will be held in the last quarter, possibly in Turin where the concerned countries will participate and there a further guideline will be issued for more broad based institutionalisation from January 1998.

Appendix 2 Common Country Assessment Process Note

Background

In December 1995, the Joint Consultative Group on Policy (JCGP) recognised that a critical first step towards harmonising their diverse programming processes was to develop a Common Country Assessment (CCA) initiative within the Resident Coordinator system.

Each JCGP organisation would bring its distinct perspective and experience to this approach and it was expected that the CCA would include a minimum set of indicators relating to internationally agreed policy agendas, as reflected in the mandates of the JCGP members and their corresponding national priorities.

At the CCA Workshop held in Rome during May 1996, it was decided that Ghana, along with Morocco, undertake the initial CCAs. UNICEF volunteered to be the lead agency in Ghana and be responsible for compiling the CCA database of core indicators.

Following on from the Rome workshop, individual CCA focal persons were assigned by each JCGP agency in Ghana to coordinate with the UNICEF focal person who was tasked with coordinating the collection and analysis of data. This task was finished in September and all agencies received copies of the draft database at the time. In addition copies and diskettes were taken to the 18th Turin Senior Management Training in October.

At the JCGP Subgroup on Programming meeting of 31 January 1997 held in New York, it was decided that an Inter-Agency team from HQs would visit Ghana in February 1997. The purpose of their visit would be to assist the development of the Ghana CCA and to prepare a paper on the process. Furthermore, it was decided that each Agency would inform its Office in Ghana about the mission and attach appropriate staff to the exercise.

JCGP Mission to Ghana

A team of HQ staff from UNDP, UNICEF and UNFPA visited Ghana to provide support to develop a CCA methodology to be used by the JCGP team in Ghana. It was also intended to be a learning experience for the New York based staff. The four-member mission was fielded from February 17th to 28th, 1997. Three members of the mission worked with the members of the JCGP from February 17 to 21st while the remaining Officer continued working with the team until the 28th February.

The UNICEF country team initiated and compiled the CCA database and prior to the arrival of the team from headquarters, the JCGP partners in Ghana were already collaborating in data collation for the CCA database. The data that was collected became the basis on which this pilot exercise was carried out.

The working group was formed with each JCGP agency in Ghana participating. In the initial meeting, the UNICEF HQ participant briefed the group on the history of the CCA up to that point. Drawing on the Rome meeting paper, it was agreed, as a first step, to try to link the set of indicators that had been collected in the Ghana CCA database to the major UN Summits. It was recognised that the various summits were quite different in the detail at which the plans of actions were agreed, from being very specific to being very general. Members of the working group were then tasked with assigning the database indicators to the conferences and summits relating to their specific agency. It was also suggested that identifying missing information gaps would be extremely useful in determining an improved assessment in the future. It was agreed that this was a test of the process and that gaps were inevitable, but that if the overall CCA process proved useful that it could be developed further by the country team. Once the basic information was related to the summits and adjusted in the database developed by the country team, the next phase would be to have a round-table discussion to form a consensus on the trends suggested by the information or whether the information would need to be challenged by cross-reference to other indicators.

The working group and Heads of Agencies agreed, that while the CCA process in Ghana should initially concentrate on the JCGP agencies in Ghana, at a later stage it should be broadened to include the GoG. It was also hoped that the CCA would serve as a useful entry point into the Country Strategic Note (CSN) process in Ghana. The JCGP members should also pursue the feasibility of expanding the process to cover other agencies outside the JCGP, under the Resident Coordinator System.

Having worked in agency-specific teams to relate the information to the particular summits, the working group met again for a progress meeting. In this second meeting the leadership of the process was taken on by the UNDP Deputy Resident Representative, on behalf of the Resident Coordinator System. At this meeting the working group felt that the process being followed should be continued, with the understanding that it was a test of the process and information gaps would remain because of the limited time available.

The group assembled the following day (their fourth) with printouts of the information according to summit. The assessment process emphasised the use of information to highlight problems that need to be addressed. The discussions were rich and the conclusions were noted (see Appendix 3). There were also interesting aspects which showed that the same information could be viewed differently from the one summit to another.

The results were compiled by the country team for a briefing meeting with the JCGP Representatives in the country. After receiving guidance from the agency heads, the country team would compile a draft report of the CCA. The country team are also expected to advise HQ on what the country team's conclusions were concerning the process followed and what advice they would give to strengthen the process in the future. Given the speed that this process was carried out, based on the need to report to the JCGP general meeting in Geneva in early April, the results of the process in Ghana should be regarded purely as a 'first attempt'.

Subsequent to the report being finalised, the Resident Coordinator will plan an informal briefing session for the government

on the CCA, the process followed in Ghana by the JCGP agencies and will also use the results to help shape the agenda UN CSN discussion with the government scheduled for 25-26 April 1997.

Assessment

It should be stressed that the CCA Working Group in Ghana greatly appreciated the presence of the JCGP Mission from headquarters and was on the whole pleased with the facilitation role it provided. However, in terms of emulating the CCA in other countries, the following constraints should be noted.

Since the Ghana pilot study demands the submission of the CCA report by mid-March 1997, it was clear that, to some extent, the quality of the CCA report would be compromised.

Ideally a slightly longer, staggered time-frame should be employed as both the assessment and collaborative processes are time-consuming. Greater advance notification would also allow members of the working group to plan ahead and thereby devote more time to the process.

In addition the list of common and agency specific indicators, compiled by the technical team from New York, was only presented to the working group at the end of the first working week. Ideally, this should be submitted to the Country Offices during the setting up of the database.

Appendix 3: Report on the 1st CCA Review Meeting

The purpose of the meeting was to review the existing CCA database in terms of the declarations of the various World Summits since 1990. The following Summits were used as a reference: *World Summit for Children (WSC), New York, 1990; International Conference on the Environment, Rio, 1993; International Conference on Population and Development, Cairo, 1994; World Social Summit, Copenhagen, 1995; Fourth International Conference on Women, Beijing, 1995; World Food Summit, Rome, 1996.*

The following were the major observations:

1. Of the three mortality rates, viz, MMR (740 per 100,000), U5MR (119 per 1,000) and IMR, (66 per 1,000) only the U5MR was on track in relation to the WSC goals. Whilst there have been some improvement in the IMR, the MMR was still extremely high and was seen as constituting a serious problem which should be addressed.
2. In the area of Family Planning, there is an urgent need to move from awareness to acceptance. Currently, only 10 per cent of the 97 per cent who are aware, use modern methods of contraception. This was seen as extremely low, despite the significant increase in recent years, and in urgent need of further investigation.
3. The goal to reduce U5 malnutrition rates by half by the year 2000 is substantially off track. Whilst there have been some marginal improvement in underweight (from 31% in 1988 to 27.7% in 1993) and stunting (from 30% in 1988 to 26.2% in 1993), wasting (from 8% in 1988 to 11.5% in 1993) on the other hand is on the increase. This raises the broader issue of the relevance of the figures purporting to show a fall in the level poverty.
4. Notwithstanding the major gains made in the eradication of guinea worm, the number of villages still affected is very high. There is therefore the need to maintain the momentum of the earlier phases and in this respect the increase in the number of cases in 1995 is a cause for concern.
5. When the group looked at safe drinking water and sanitation under the Rio goals, the increased access was seen as a positive trend. However, when looked at in terms of the WSC goals of universal access, Ghana was off target. This led the group to question the practicality of the WSC goals of universal safe drinking water and universal access to clean sanitation in Ghana. Furthermore the group recognised the need to investigate whether increased access has led to a reduction in the prevalence of water borne diseases in the country.
6. With regard to the participation of women in decision making, the group considered that, at present, there is insufficient data to assess trends. The Conference on the Eradication of all forms of Discrimination against Women (CEDAW) Report may provide information on assessing progress.
7. In respect of the World Food Summit Declaration on household food security, the group observed that the absence of data on household food security in Ghana makes any assessment of the situation difficult. Given the negative trends in malnutrition rates, the need for more information on household food security was emphasised.
8. The WSC goal of maintaining at least 90% immunisation coverage for children under one by the year 2,000 is clearly in trouble. The impetus has not been maintained since 1990, and this has been reflected in increased numbers of cases. Between 1990 and 1994, coverage against DPT, measles, polio and TB all fell by a couple of percentage points.

Appendix 4

Data gaps for the Common Country Assessment

Information, where available was related to each agency's particular summit. During the assessment, it emerged that there were certain data gaps. Indicators for which there was no data available at the time of the assessment are included in the database listing (Appendix 5).

The following are the areas in each summit for which information was not available at the time of the assessment:

1. Fourth International

Conference on Women, Beijing

At the time of the assessment data in the specific areas of focus by the Women's Conference was not available. The CCA country team in Ghana is in the process of compiling data and indicators relevant to the Fourth International Conference on Women.

2. World Food Summit 1996

The World Food Summit (WAS), held in November 1996 among other declarations, reaffirmed the right of everyone to have access to safe and nutritious food and the right to food security. The Summit also pledged to reduce the number of undernourished people worldwide to half their present level by the year 2015.

However, with the Summit held only three months ago, it is too early to assess its impact on the Ghana situation in terms of the Summit's declarations. In any case, the negative trends in malnutrition rates as reported by UNICEF under the assessment of the Ghana situation within the context of the World Summit for Children, Rome 1990 suggests the situation cannot be any better now than before the WAS.

Although some aggregate data on household food security was collected in the GLSS surveys, there is a need for timely, reliable, desegregated data on household incomes, household food production and consumption patterns in order to assess the level of food security at the household level.

3. World Social Summit

Substantive data gaps exist in some areas of focus of the World Social Summit.

- * Data on employment and sustainable livelihoods.
- * Social integration

4. World Summit for Children

The areas in which substantive data gaps existed are as follows:

- * Data on provision of improved protection of children
- * Data on virtual elimination of Iodine Deficiency Disorders
- * Data on Virtual Elimination of Vitamin A deficiency
- * Data on Acute Respiratory infections
- * Facts for Life use

5. Monitoring Child Rights

To date there have been several studies on child labor, street children, disabled children etc. In addition, UNICEF in collaboration with the World Bank is currently funding a child labor study. It is expected that a desk review of the existing data will provide the CCA with information to fill the existing data gaps.

The major areas in which information gaps exist are:

- * Child labor
- * Disabled children
- * Children involved in dangerous labor activities
- * Children involved in unlawful sexual practices

Appendix 5

CCA Database Listing

WORLD SOCIAL SUMMIT(Copenhagen)

INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Underweight - moderate and severe/Percent	1988	31	DHS (1988)
	1993	27.7	DHS (1993)
Underweight - severe/Percent	1988	7.1	DHS (1988)
	1993	8	DHS (1993)
Population in absolute poverty - Urban (%) /Percent	1988	27.4	GLSS1, Ghana Living Standards Survey 1987/88
	1989	31.4	GLSS2, Ghana Living Standards Survey 1988/89
	1992	26.5	GLSS3, Ghana Living Standards Survey 1992
Population in absolute poverty - Rural (%) /Percent	1988	41.9	GLSS1, Ghana Living Standards Survey 1987/88
	1989	37.6	GLSS2, Ghana Living Standards Survey 1988/89
Rate of inflation (%) /Percent	1988	31	Consumer Price Index
	1989	25	Consumer Price Index
	1990	37	Consumer Price Index
	1991	18	Consumer Price Index
	1992	10	Consumer Price Index
	1993	25	Consumer Price Index

INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Propn. of Population below Poverty Line/Percent	1994	25	Consumer Price Index
	1995	56	Consumer Price Index
	1988	36.9	GLSS1, Ghana Living Standards Survey 1987/88
	1989	41.8	GLSS2, Ghana Living Standards Survey 1988/89
	1992	31.4	GLSS3, Ghana Living Standards Survey 1992
Popn. below consumption-based poverty line/Percent	1988	0	No data available
GDP growth rate minus employment growth	1988	0	No data available
Employment growth rate minus labor force rate/Percent	1988	0	No data available
% urban labor force in informal/sex sector/Percent	1988	0	No data available
Average Urban skilled wage/Absolute	1988	0	No data available
Income Share of poorest 40% of population/Percent	1988	0	No data available
Number of newspapers per 1000 people/Per 1,000	1988	0	No data available
Number of radios per 1000 people/Per 1,000	1988	0	No data available
No. of Civil society organizations /100,000/Per 100,000	1988	0	No data available
No. of Political parties in elections/Absolute	1988	0	No data available
Percent of registered voters who vote/Percent	1988	0	No data available
Percent of popn. with access to electricity/Percent	1988	0	No data available

INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Aggregate net resource flow as % of GNP/Percent	1988	0	No data available
NPV of total external debt as % of GNP/Percent	1988	0	No data available
Gross Domestic Savings as % of GDP/Percent	1988	0	No data available
INTERNATIONAL CONFERENCE ON THE ENVIRONMENT (Rio)			
INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Number of people per room/Absolute	1988	0	No data available
Agricultural output/person employed/hectare/Absolute	1988	0	No data available
Local emissions of CO ₂ s, SO ₂ s, NO _x s/Absolute	1988	0	No data available
Arable land per capita/Absolute	1988	0	No data available
Vegetation Index/Index	1988	0	No data available
Threatened species as a % of total native sp./Ratio	1988	0	No data available
Change in Forest Area/Percent	1988	0	No data available
WORLD SUMMIT FOR CHILDREN			
Reduce U5 malnutrition by 1/2			
INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Underweight - moderate and severe/Percent	1988	31	DHS (1988)
	1993	27.7	DHS (1993)
Underweight - severe/Percent	1988	7.1	DHS (1988)
	1993	8	DHS (1993)
Stunting - moderate and severe/Percent	1988	30	DHS (1988)
	1993	26.2	DHS (1993)

INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Stunting - severe/Percent	1988	10.2	DHS (1988)
	1993	9.1	DHS (1993)
Wasting - moderate and severe/Percent	1988	8	DHS (1988)
	1993	11.5	DHS (1993)
Wasting - severe/Percent	1988	1	DHS (1988)
	1993	2.3	DHS (1993)
Universal access to safe drinking water			
INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Access to safe drinking water - rural/Percent	1990	24	UNICEF/Government of Ghana, 1990
	1991	35	UNICEF/Government of Ghana, 1990
	1992	46	Ghana Water and Sanitation Survey, 1992
	1995	52	MICS 1995
Universal access to sanitation			
INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Access to sanitation - total/Percent	1990	27	UNICEF/Government of Ghana, 1990
	1991	42	UNICEF/Government of Ghana, 1990
Access to sanitation - urban/Percent	1992	29	Ghana Water and Sanitation Survey, 1992
	1995	32	MICS 1995
	1991	64	UNICEF/Government of Ghana, 1990
	1992	61	Ghana Water and Sanitation Survey, 1992
	1995	75	MICS 1995
Strengthen Basic Education			

INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Learning achievement/Percent	1990	0	No data available
	1995	0	No data available
Propn. entering grade 1 at recommended age/Percent	1995	63	MICS 1995
Attention to female health/nutrition			
INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Under five mortality rate - female/Per 1000	1993	111	DHS (1993)
Underweight - moderate and severe - female/Percent	1988	27.4	DHS (1988)
	1993	25.9	DHS (1993)
Care of pregnant women/Percent	1992	77	1984 Population Census of Ghana
	1993	86	DHS (1993)
Contd breastfeeding rate at 2 yrs (20-23 mos)/Percent	1988	51.7	DHS (1988)
	1993	53	DHS (1993)
	1995	48	MICS 1995
HIV prevalence among adult population/Percent	1996	4	National AIDS Control Programme. MOH
Access to prenatal care			
INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Facilities providing essential obstetric care/Ratio	1995	0	No data available
Care of pregnant women/Percent	1992	77	1984 Population Census of Ghana
	1993	86	DHS (1993)
Reduce Low Birth Weight to less than 10%			
INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Low birthweight/Percent	1988	17	DHS (1988)

INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
	1993	1.8	DHS (1993)
Reduce 1990 anaemia by 1/3			
INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Females with low haemoglobin (15-49 yrs.)/Percent	1995	0	No data available
Eliminate iodine deficiency disorder			
INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Goitre in school children/Percent	1993	10	WHO/UNICEF/IC CIDD, MDIS Working Paper #1, July 1993
Propn. of HHs consuming adeq. iodized salt/Percent	1990	0	UNICEF Ghana
	1995	0.3	MICS 1995
Low urinary iodine/Percent	1995	0	No data available
Propn. of newborns with serum TSH > 5mI/Percent	1995	0	No data available
Eliminate Vit A disorder			
INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Children with nightblindness/Percent	1995	0	No data available
Low vitamin A/Percent	1995	0	No data available
Breastmilk low in vitamin A/Percent	1995	0	No data available
Empowerment to breastfeed			
INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Exclusive breastfeeding rate (< 4 mos)/Percent	1988	2	DHS (1988)
	1993	8	DHS (1993)
	1995	19	MICS 1995

INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Timely complementary feeding rate (6-9 mos)/Percent	1988	57	DHS (1988)
	1993	36	DHS (1993)
	1995	63	MICS 1995
Contd breastfeeding rate at 2 yrs (20-23 mos)/Percent	1988	51.7	DHS (1988)
	1993	53	DHS (1993)
	1995	48	MICS 1995
Eradicate polio			
INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Annual number of cases of polio/Absolute	1984	115	Disease Control Unit, Ministry of Health
	1985	185	Disease Control Unit, Ministry of Health
	1986	117	Disease Control Unit, Ministry of Health
	1987	84	Disease Control Unit, Ministry of Health
	1988	60	Disease Control Unit, Ministry of Health
	1989	113	Disease Control Unit, Ministry of Health
	1990	60	Disease Control Unit, Ministry of Health
	1991	31	Disease Control Unit, Ministry of Health
	1992	3	Disease Control Unit, Ministry of Health
	1993	19	Disease Control Unit, Ministry of Health
1994	33	Disease Control Unit, Ministry of Health	
1995	30	Disease Control Unit, Ministry of Health	

INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Elimination of neonatal tetanus by 1995			
INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Annual number of cases of neonatal tetanus/Absolute	1993	9	Disease Control Unit, Ministry of Health
	1994	144	Disease Control Unit, Ministry of Health
	1995	216	Disease Control Unit, Ministry of Health
Eradicate measles			
INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Annual number of cases of measles/Absolute	1984	40179	Disease Control Unit, Ministry of Health
	1985	64577	Disease Control Unit, Ministry of Health
	1986	11099	Disease Control Unit, Ministry of Health
	1987	24781	Disease Control Unit, Ministry of Health
	1988	40456	Disease Control Unit, Ministry of Health
	1989	19997	Disease Control Unit, Ministry of Health
	1990	32246	Disease Control Unit, Ministry of Health
	1991	17135	Disease Control Unit, Ministry of Health
	1992	39933	Disease Control Unit, Ministry of Health
	1993	34641	Disease Control Unit, Ministry of Health

INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Under-five deaths from measles/Absolute	1994	34671	Disease Control Unit, Ministry of Health
	1995	43078	Disease Control Unit, Ministry of Health
	1995	0	No data available
90% immunization coverage			
INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
1 year olds immunized against DPT/Percent	1987	18	EPI/CDD, Disease Control Unit Ministry of Health, Ghana
	1988	36	EPI/CDD, Disease Control Unit Ministry of Health, Ghana
	1989	36	EPI/CDD, Disease Control Unit Ministry of Health, Ghana
	1990	50	EPI/CDD, Disease Control Unit Ministry of Health, Ghana
	1991	40	EPI/CDD, Disease Control Unit Ministry of Health, Ghana
	1992	40	EPI/CDD, Disease Control Unit Ministry of Health, Ghana
	1993	48.1	EPI/CDD, Disease Control Unit Ministry of Health, Ghana
	1994	48.1	EPI/CDD, Disease Control Unit Ministry of Health, Ghana
	1995	59	MICS 1995
	1995	59	MICS 1995

INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
1 year olds immunized against measles/Percent	1987	28	EPI/CDD, Disease Control Unit
			Ministry of Health, Ghana
	1988	59	EPI/CDD, Disease Control Unit
			Ministry of Health, Ghana
	1989	44	EPI/CDD, Disease Control Unit
			Ministry of Health, Ghana
	1990	52	EPI/CDD, Disease Control Unit
			Ministry of Health, Ghana
	1991	40	EPI/CDD, Disease Control Unit
			Ministry of Health, Ghana
	1992	43	EPI/CDD, Disease Control Unit
			Ministry of Health, Ghana
	1993	49.5	EPI/CDD, Disease Control Unit
			Ministry of Health, Ghana
	1994	49.2	EPI/CDD, Disease Control Unit
			Ministry of Health, Ghana
	1995	55.1	MICS 1995
	1995	55.1	MICS 1995
1 year olds immunized against polio/Percent	1987	18	EPI/CDD, Disease Control Unit
			Ministry of Health, Ghana
	1988	37	EPI/CDD, Disease Control Unit
			Ministry of Health, Ghana
	1989	36	EPI/CDD, Disease Control Unit
			Ministry of Health, Ghana
	1990	50	EPI/CDD, Disease Control Unit

INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
			Ministry of Health, Ghana
	1991	40	EPI/CDD, Disease Control Unit
			Ministry of Health, Ghana
	1992	39	EPI/CDD, Disease Control Unit
			Ministry of Health, Ghana
	1993	47	EPI/CDD, Disease Control Unit
			Ministry of Health, Ghana
	1994	48	EPI/CDD, Disease Control Unit
			Ministry of Health, Ghana
	1995	51	MICS 1995
	1995	51	MICS 1995
1 year olds immunized against TB/Percent	1987	35	EPI/CDD, Disease Control Unit
			Ministry of Health, Ghana
	1988	37	EPI/CDD, Disease Control Unit
			Ministry of Health, Ghana
	1989	70	EPI/CDD, Disease Control Unit
			Ministry of Health, Ghana
	1990	71	EPI/CDD, Disease Control Unit
			Ministry of Health, Ghana
	1991	56	EPI/CDD, Disease Control Unit
			Ministry of Health, Ghana
	1992	61	EPI/CDD, Disease Control Unit
			Ministry of Health, Ghana
	1993	68.2	EPI/CDD, Disease Control Unit
			Ministry of Health, Ghana

INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
	1994	61	EPI/CDD, Disease Control Unit
			Ministry of Health, Ghana
	1995	67	MICS 1995
Pregnant women immunized against tetanus/Percent	1995	67	MICS 1995
	1992	9	UNICEF/WHO, EPI
	1993	14	CRING94
	1994	11	UNICEF EPI Information System (EIS)
			MICS 1995
Children protected against neonatal tetanus/Percent	1995	64	MICS 1995
Reduce diarrhoea deaths and cases			
INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Avg annual number of episodes of diarrhoea U5/Absolute	1995	0	No data available
Use of ORT (pre 1993 definition)/Percent	1989	19	1984 Population Census Report, 1996
	1990	40	CRING94
	1992	44	CRING94
	1993	42.2	DHS (1993)
	1995	93	MICS 1995
Use of ORT (incrstd fluids) with cntd feeding/Percent	1995	24	MICS 1995
Under-five deaths from diarrhoea/Absolute	1993	33000	UNICEF CDD/ARI
Reduce ARI deaths by 1/3			
INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Under-five deaths from ARI/Absolute	1995	0	No data available
Eliminate Guineaworm disease			
INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE

INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Annual number of cases of dracunculiasis/Absolute	1989	179556	Guinea Worm Eradication Program Report, 1995
	1990	123793	Guinea Worm Eradication Program Report, 1995
	1991	66697	Guinea Worm Eradication Program Report, 1995
	1992	33464	Guinea Worm Eradication Program Report, 1995
	1993	17918	Guinea Worm Eradication Program Report, 1995
	1994	7104	Guinea Worm Eradication Program Report, 1995
	1995	8894	Guinea Worm Eradication Program Report, 1995
	No. villages with any case of dracunculiasis/Absolute	1992	3105
1995		1768	Guinea Worm Eradication Program Report, 1995
Early childhood development			
INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Underweight - moderate and severe/Percent	1988	31	DHS (1988)
	1993	27.7	DHS (1993)
Underweight - severe/Percent	1988	7.1	DHS (1988)
	1993	8	DHS (1993)
Preschool development/Percent	1995	0	No data available

INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
CONVENTION ON THE RIGHTS OF THE CHILD			
Basic Health and welfare			
INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Underweight - moderate and severe/Percent	1988	31	DHS (1988)
	1993	27.7	DHS (1993)
Underweight - severe/Percent	1988	7.1	DHS (1988)
	1993	8	DHS (1993)
Percent of children disabled/Percent	1988	0	No data available
Disabled children receiving special services/Percent	1988	0	No data available
Percentage of 1 year olds fully immunized/Percent	1992	21	1984 Population Census Report, 1996
	1993	43	DHS (1993)
	1995	51	MICS 1995
Education, leisure and culture			
INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Net primary school enrolment ratio - total/Percent	1988	67	DHS (1988)
	1992	74.6	GLSS3, Ghana Living Standards Survey 1992
	1995	70	MICS 1995
Net Secondary School Enrolment/Percent	1988	0	No data available
Special protection measures			
INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Children below 15 years in full-time work/Percent	1988	0	No data available
Children involved in prostitution/Percent	1988	0	No data available
Children affected by armed conflicts/Percent	1988	0	No data available

INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Implementing and reporting CRC			
INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Percent of Population knowing of CRC/Percent	1988	0	No data available
Civil Rights			
INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
% of children officially registered at birth/Percent	1988	0	No data available
Family environment and alternative care			
INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Percent of children not living with parents/Percent	1988	0	No data available
Percent of children below poverty line/Percent	1988	0	No data available
INTERNATIONAL CONFERENCE ON POPULATION (Cairo)			
INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Births attended by trained health personnel/Percent	1988	40	DHS (1988)
	1993	59	DHS (1993)
	1994	41	Ministry of Health Report, 1994
Care of pregnant women/Percent	1993	86	DHS (1993)
	1994	82	Ministry of Health Report, 1994
Exclusive breastfeeding rate (< 4 mos)/Percent	1988	2	DHS (1988)
	1993	8	DHS (1993)
	1995	19	MICS 1995
Crude Birth Rate/Per 1,000	1993	38	DHS (1993)

INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Crude Death Rate/Per 1,000	1994	39.4	UN Population Division, 1994 Revision
	1993	0	No data available
	1994	10.5	UN Population Division, 1994 Revision
Contraceptive Prevalence Rate/Percent	1988	5	DHS (1988)
	1993	10.1	DHS (1993)
Propn. of births to women below 20	1994	18	Ministry of Health Report, 1994
Prevalence of RTIs/Absolute	1988	0	No data available
Prevalence of STDs/Absolute	1988	0	No data available
Years Doubling time of Population/Absolute	1984	23	1984 Population Census Report, 1996
Number of Women aged 15-49 years/Absolute	1996	0	No data available
Currently Married Women aged 15-49 years/Absolute	1996	0	No data available
Unmet Need for FP (all and adolescents)/Percent	1993	0	No data available
No. of SDPs offering FP services/10000 women/Per 10,000	1993	0	No data available
Popn. having access to Basic Health Services/Percent	1993	0	No data available
Women per 100 men in technical occupations/Ratio	1990	10.5	Human Development Report 1996
Propn. of Population below Poverty Line/Percent	1988	36.9	GLSS1, Ghana Living
			Standards Survey 1987/88
	1989	41.8	GLSS2, Ghana Living
			Standards Survey 1988/89
	1992	31.4	GLSS3, Ghana Living

INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
			Standards Survey 1992
Popn. below consumption-based poverty line/Percent	1988	0	No data available
% of Parliamentary seats held by women/Percent	1992	8	Ghana Electoral Commission, 1995
	1994	9	Ghana Electoral Commission, 1995
Births by appropriately trained health pers./Percent	1988	0	No data available
FOURTH INTERNATIONAL WOMEN'S CONFERENCE - BEIJING			
Women and Power/Decision making			
INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
No. of SDPs offering FP services/10000 women/Per 10,000	1990	9	
Popn. having access to Basic Health Services/Percent	1990	36	Human Development Report 1996
Women per 100 men in technical occupations/Ratio	1990	10.5	Human Development Report 1996
% of Parliamentary seats held by women/Percent	1992	8	Ghana Electoral Commission, 1995
	1994	9	Ghana Electoral Commission, 1995
% women in Administrative/Managerial posts/Percent	1984	9	1984 Population Census Report, 1996
Percent of registered eligible voters/Percent	1994	49.7	Ghana Electoral Commission, 1995
% of women Elected District Assembly Members/Percent	1994	3	Ghana Electoral Commission, 1995
% women candidates in Parliamentary election/Percent	1992	7	Ghana Electoral Commission, 1995
	1994	8	Ghana Electoral Commission, 1995

INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Percent of women at ministerial level/Percent	1994	12	Population Reference Bureau, 1995
Women in Education and Training			
INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Net primary school enrolment ratio - male/Percent	1992	77	GLSS3, Ghana Living Standards Survey 1992
	1995	70	MICS 1995
Net primary school enrolment ratio - female/Percent	1992	71.9	GLSS3, Ghana Living Standards Survey 1992
	1995	69	MICS 1995
Net Secondary School Enrolment/Percent	1988	26.6	GLSS1, Ghana Living Standards Survey 1987/88
	1988	26.6	GLSS1, Ghana Living Standards Survey 1987/88
	1989	26.9	GLSS2, Ghana Living Standards Survey 1988/89
	1989	26.9	GLSS2, Ghana Living Standards Survey 1988/89
	1992	33.7	GLSS3, Ghana Living Standards Survey 1992
	1992	33.7	GLSS3, Ghana Living Standards Survey 1992
Percent of popn. aged 15+ who can read/Percent	1988	28	GLSS1, Ghana Living Standards Survey 1987/88
	1988	28	GLSS1, Ghana Living Standards Survey 1987/88
	1989	30	GLSS2, Ghana Living Standards Survey 1988/89
	1989	30	GLSS2, Ghana Living Standards Survey 1988/89
Percent of popn. aged 15+ who can write/Percent	1988	27	GLSS1, Ghana Living Standards Survey 1987/88

INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Percent of popn. aged 15+ who can calculate/Percent	1988	27	GLSS1, Ghana Living Standards Survey 1987/88
	1989	27	GLSS2, Ghana Living Standards Survey 1988/89
	1989	27	GLSS2, Ghana Living Standards Survey 1988/89
	1988	35	GLSS1, Ghana Living Standards Survey 1987/88
	1988	35	GLSS1, Ghana Living Standards Survey 1987/88
	1989	64	GLSS2, Ghana Living Standards Survey 1988/89
	1989	64	GLSS2, Ghana Living Standards Survey 1988/89
Maternal mortality rate/Per 100,000	1992	214	Infant, Child and Maternal Mortality Survey, 1992
	1995	740	WHO/UNICEF, January 1996
Contraceptive prevalence rate/Percent	1988	5	DHS (1988)
	1993	10.1	DHS (1993)
Total fertility rate/Index	1980	6.5	Ghana Fertility Survey, 1979-1980
	1988	6.4	DHS (1988)
	1992	6	CRING94
Life expectancy at birth (Female)/Absolute	1993	5.5	DHS (1993)
	1993	58	Human Development Report 1996
The Girl Child			
INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Life expectancy at birth (Female)/Absolute	1993	58	Human Development Report 1996
Life expectancy at birth (Male)/Absolute	1993	0	No data available

INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Propn. of women 15-19 who marry before age 20/Percent	1988	24	DHS (1988)
	1993	22	DHS (1993)
Propn. of women 15-19 w/ 1st births before 20/Percent	1988	19	DHS (1988)
	1993	19	DHS (1993)
Propn. of women 15-19 who had 1st sexual int./Percent	1993	59	DHS (1993)
Percent of girls 6-11 years in primary sch./Percent	1991	45	Ministry of Education, Ghana
	1993	46	Ministry of Education, Ghana
	1995	46	Ministry of Education, Ghana
Percent of girls 12-17 yrs in secondary sch./Percent	1991	39	Ministry of Education, Ghana
	1993	40	Ministry of Education, Ghana
	1995	41	Ministry of Education, Ghana
Percent of girls enrolled in Technical Inst./Percent	1991	9	Ministry of Education, Ghana
	1993	10	Ministry of Education, Ghana
	1995	9	Ministry of Education, Ghana
Percent of girls enrolled in Universities/Percent	1991	21	Ministry of Education, Ghana
	1993	22	Ministry of Education, Ghana
	1995	24	Ministry of Education, Ghana
Average number of years of schooling (girls)/Absolute	1993	2.2	Ministry of Education, Ghana
Percent of TFR contributed by women 15-19 yrs/Percent	1988	10	DHS (1988)
	1993	11	DHS (1993)
Common Indicators			
INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE

INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Infant mortality rate/Per 1,000	1988	77	DHS (1988)
	1992	82	Infant, Child and Maternal Mortality Survey, 1992
Under-five mortality rate/Per 1,000	1993	66	DHS (1993)
	1988	155	DHS (1988)
	1992	132	Infant, Child and Maternal Mortality Survey, 1992
Maternal mortality rate/Per 100,000	1993	119	DHS (1993)
	1992	214	Infant, Child and Maternal Mortality Survey, 1992
Access to safe drinking water - total/Percent	1995	740	WHO/UNICEF, January 1996
	1990	49	UNICEF/Government of Ghana, 1990
	1991	52	UNICEF/Government of Ghana, 1990
	1992	57	Ghana Water and Sanitation Survey, 1992
Access to safe drinking water - urban/Percent	1995	65	MICS 1995
	1990	93	UNICEF/Government of Ghana, 1990
	1991	93	UNICEF/Government of Ghana, 1990
	1992	76	Ghana Water and Sanitation Survey, 1992
Access to safe drinking water - rural/Percent	1995	88	MICS 1995
	1990	24	UNICEF/Government of Ghana, 1990
	1991	35	UNICEF/Government of Ghana, 1990
	1992	46	Ghana Water and Sanitation Survey, 1992
	1995	52	MICS 1995

INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Access to sanitation - rural/Percent	1991	32	UNICEF/Government of Ghana, 1990
	1992	11	Ghana Water and Sanitation Survey, 1992
	1995	25	MICS 1995
Net primary school enrolment ratio - total/Percent	1988	67	DHS (1988)
	1992	74.6	GLSS3, Ghana Living Standards Survey 1992
Net primary school enrolment ratio - male/Percent	1995	70	MICS 1995
	1992	77	GLSS3, Ghana Living Standards Survey 1992
	1995	70	MICS 1995
Net primary school enrolment ratio - female/Percent	1992	71.9	GLSS3, Ghana Living Standards Survey 1992
	1995	69	MICS 1995
Adult literacy rate - total (15 yrs & older)/Percent	1990	60	CRING94
	1992	48.8	GLSS3, Ghana Living Standards Survey 1992
	1995	64.5	UNESCO Statistical yearbook, 1995
Adult literacy rate - male (15 yrs & older)/Percent	1990	70	CRING94
	1992	60.8	GLSS3, Ghana Living Standards Survey 1992
	1995	75.9	UNESCO Statistical yearbook, 1995
Adult literacy rate - female (15 yrs & older)/Percent	1992	38.5	GLSS3, Ghana Living Standards Survey 1992
Contraceptive prevalence rate/Percent	1993	43	DHS (1993)
	1995	53.5	UNESCO Statistical yearbook, 1995
	1988	5	DHS (1988)
	1993	10.1	DHS (1993)

INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Total fertility rate/Index	1980	6.5	Ghana Fertility Survey, 1979-1980
	1988	6.4	DHS (1988)
	1992	6	CRING94
Births attended by trained health personnel/Percent	1993	5.5	DHS (1993)
	1988	40	DHS (1988)
Total population/Absolute	1993	59	DHS (1993)
	1984	12296081	1984 Population Census Report, 1996
Population under five years (total)/Absolute	1984	2030082	1984 Population Census Report, 1996
Population under five years (male)/Absolute	1984	1015167	1984 Population Census Report, 1996
Population under five years (female)/Absolute	1984	1014915	1984 Population Census Report, 1996
Adult literacy rate females as % of males/Percent	1993	0	No data available
Population annual growth rate (%)/Percent	1995	3.1	1984 Population Census Report, 1996
Fertility rate for women 15 to 19/Ratio	1988	1.11	DHS (1988)
	1993	1.2	DHS (1993)
Life expectancy at birth (Female)/Absolute	1993	58	Human Development Report 1996
Life expectancy at birth (Male)/Absolute	1993	0	No data available
Total population (male)/Absolute	1984	6063848	1984 Population Census Report, 1996
Total population (female)/Absolute	1984	6232233	1984 Population Census Report, 1996
Population 0-14 years (total)/Absolute	1984	5535114	1984 Population Census Report, 1996
Population 0-14 years (female)/Absolute	1984	2732335	1984 Population Census Report, 1996

INDICATOR/VALUE	DATE	VALUE	SOURCE OF VALUE
Population 0-14 years (male)/Absolute	1984	2802779	1984 Population Census Report, 1996
Population 15-59 years (total)/Absolute	1984	5841830	1984 Population Census Report, 1996
Population 15-59 years (female)/Absolute	1984	2930021	1984 Population Census Report, 1996
Population 15_59 years (male)/Absolute	1984	2911809	1984 Population Census Report, 1996
Population 60 years and older (Total)/Absolute	1984	371085	1984 Population Census Report, 1996
Population 60 years and older (female)/Absolute	1984	192839	1984 Population Census Report, 1996
Population 60 years and older (male)/Absolute	1984	178246	1984 Population Census Report, 1996
Popn. without access to adequate sanitation/Percent	1995	0	No data available
Percent of children below poverty line/Percent	1995	0	No data available
Percent of women below poverty line/Percent	1995	0	No data available