NATIONAL POPULATION COUNCIL

POPULATION STABALISATION REPORT

GHANA

2011

This report is a largely descriptive and uses secondary data from censuses, surveys and institutional data carried out by the National Population Council (NPC) with financial support from Population Communication through Partners in Population and Development. The opinions expressed in this report are those of the authors.

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LIST OF ACRONYMS

AHDP	Adolescent Health Development Programme
CBOs	Community Based Organisations
CHAG	Christian Health Association of Ghana
CHPS	Community Based Health and Planning Services
CPR	Contraceptive Prevalence Rate
DFID	UK Aid from the Department for International Development
ECOWAS	Economic Community of West African States
FCUBE	Free Compulsory Universal Basic Education
GDHS	Ghana Demographic and Health Survey
GES	Ghana Education Service
GHS	Ghana Health Service
GNFP	Ghana National Family Planning Programme
GSGDA	Ghana Shared Growth and Development Agenda (2010 – 2013)
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IGA	Income Generation Activities
IMR	Infant Mortality Rate
JHS	Junior High School
MCH	Maternal and Child Health Care
MDGs	Millennium Development Goals
MMR	Maternal Mortality Rate
MOE	Ministry of Education

MOWAC	Ministry of Women and Children's Affairs
NEPAD	New Partnership for Africa's Development
NFED	Non Formal Education Department
NGOs	Non Governmental Organisations
NHIS	National Health Insurance Scheme
NYEP	National Youth Employment Programme
PAC	Post Abortion Care
PHC	Population and Housing Census
PMTCT	Preventing Mother to Child Transmission
PPAG	Planned Parenthood Association of Ghana
RH	Reproductive Health
SHS	Senior High School
SME	Small and Medium Enterprises
STME	Sciences Technology Mathematics Education
TFR	Total Fertility Rate
UNFPA	United National Fund for Population and Development
WILDAF	Women in Law and Development in Africa

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CHAPTER ONE: GENERAL INTRODUCTION

1.0 Introduction

Ghana is situated on the West Coast of Africa off the Gulf of Guinea. It occupies a land area of 238,589 square kilometres and is bordered on the west by Cote d'Ivoire, east by Togo and the north by Burkina Faso. The country consists of ten administrative regions, subdivided into 170 districts to ensure efficient and effective administration at the local levels. Ghana's economy is mainly agricultural with crops produced for both local consumption and exports. Minerals including gold, bauxite and manganese as well as timber also contribute to the country's earnings. In 2009, Ghana attained lower middle-income status and in 2010, became an oil producing country.

As in many developing countries, Ghana's population has increased rapidly over the years from 6.7 million in 1960 to 12.4 million in 1984 and then doubled to 24.6 million in 2010 with all regions of the country experiencing growth. With a current growth rate of 2.5 percent, the population is expected to double in 28 years. The age and sex structure of the population reflects a youthful population with 38 percent of the population under 15 years of age for both sexes. With such a youthful population, there is an in-built momentum for further growth. Ghana is experiencing a demographic transition with both fertility and mortality levels declining. Ghana's population is also rapidly urbanizing with 50 percent of the population living in urban areas.

Since Ghana attained independence, a number of policies and programmes have been put in place to accelerate the growth of the economy and to raise the living standards of the people with varying degrees of success. These include Ghana Vision 2020 (1996-2000); the First Medium-Term Plan (1997- 2000); Ghana Poverty Reduction Strategy (2003-2005); Growth and Poverty Reduction Strategy (2006-2009) and the Ghana Shared Growth and Development Agenda (2010–2013).

These pragmatic policies and programmes have resulted in significant economic gains. According to the World Bank, in 2011, Ghana's economy grew at 14.4 percent boosted by new oil production and a rebounded construction sector. In recent times, the country has also witnessed a reduction in its poverty indicators with the proportion of Ghana's population defined

as poor falling from 51.7 percent in 1991/92 to 39.5 percent in 1998/99 and further to 28.5 percent in 2005/06. Despite these strides poverty still remains an important challenge. This challenge means that Ghana must optimally harness the necessary resources including reducing its rapid population growth in order to gain from investments made. The correlation between population growth and economic development has long been established. A number of studies have proven that high birth rates reduce economic growth and that declines in birth rates have shown positive impacts on per capita income yielding positive dependency effects.

The determination of the Government of Ghana to effectively manage the population for development is reflected in its commitment to global and regional agreements and conventions on population and development. These include the International Conference on Population and Development (ICPD), the Millennium Development Goals (MDGs), Beijing Platform for Action, the World Summit on Sustainable Development and NEPAD. Furthermore the Article 37, Clause 4 of the 1992 Constitution of Ghana enjoins Government to maintain a population policy that is consistent with the aspirations and development needs of the country. Ghana first adopted a Population Policy in 1969 and was the third African country to do so. The Policy was later revised in 1994 to incorporate new and emerging issues such as HIV/AIDS, the environment and gender. The revised policy provides a framework to guide the development, implementation, monitoring and evaluation of several reproductive health and population related policies, plans and programmes in the country.

The Ghana Population Stabilization report therefore provides a situation analyses of the implementation of population and development policies and programmes in Ghana, achievements, challenges as well as recommendations to inform future interventions to effectively manage Ghana's population for development.

It is significant that this report is being prepared just after the 2010 Population and Housing Census in Ghana as well as the attainment of a global population of 7 billion in October 2011. These two events both point to the growing population at both the local and global levels and its implications for development at different levels, thus emphasising the centrality of population and its strong linkage with sustained socio-economic development.

This report is therefore a clarion call for accelerated action by all stakeholders to strengthen the development, implementation, monitoring and evaluation of population and development policies, plans and programmes. The report is also expected to contribute to strengthening policy and programme interventions to improve the quality of life of the people of Ghana.

1.2 Methodology

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

1.3 Organization of Report

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

CHAPTER 2: POPULATION SITUATION ANALYSIS

2.0 Introduction

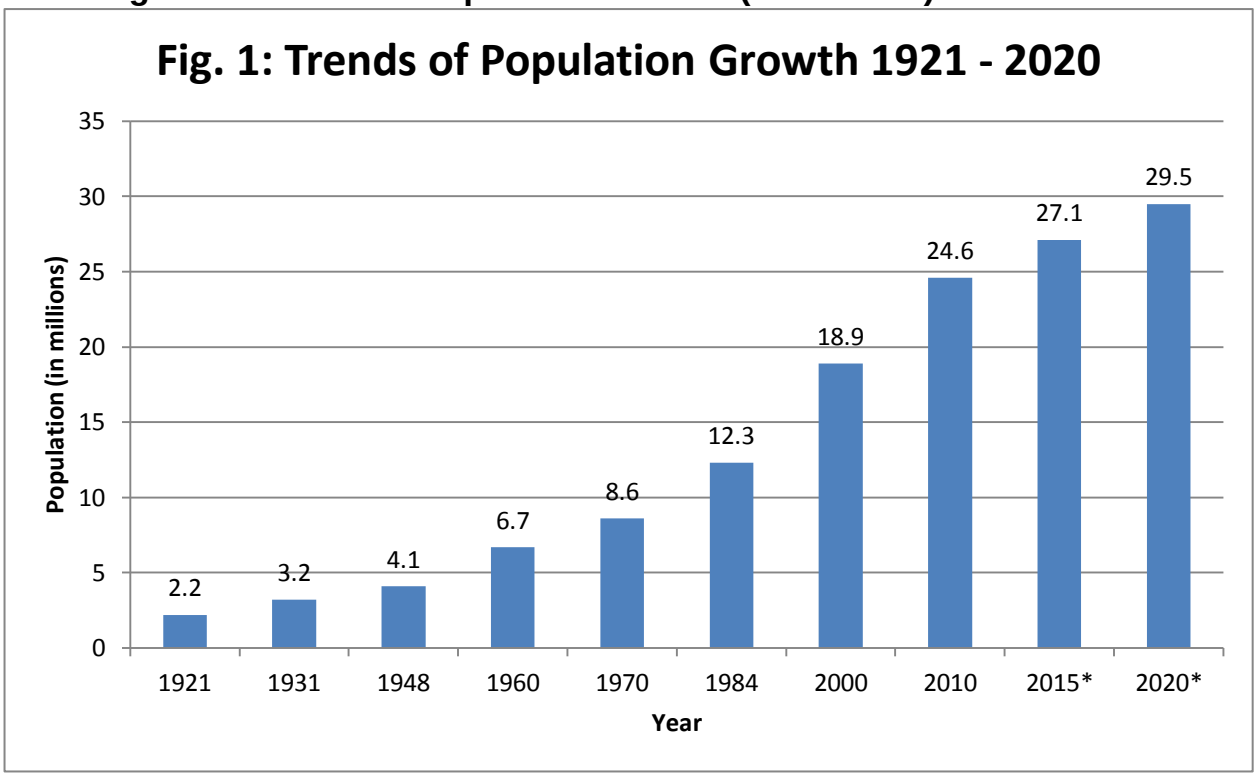
Ghana has one of the fastest growing populations in the world despite the desire of many Ghanaian women and men for better spaced and smaller families (GDHS, 2008). The rapid growth of the population has created a youthful age cohort whose numbers are still expanding and which has an in-built momentum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

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

2.1 Population Growth

In 1921, Ghana's population of just over 2 million increased to 6.7 in 1960 and 8.6 million in 1970, thus more than tripling in nearly fifty years (i.e., 1921 – 1970). Although data for the early part of the 20th century are not that reliable, they are indicative of a rapid increase in the country's population. The reported average annual growth rates of 1.6 percent in 1931 – 1948 and 4.1 percent in 1948 - 1960 suggest an acute under-enumeration. The average annual growth rates of 2.8 percent between 1921 and 1960 and 2.7 percent between 1931 and 1960 also confirm the undercount that occurred in 1948. It has been reported that the depression in the 1930s might have shrunk the immigration stream or even reversed it (Kimble 1960:88; Caldwell 1967:113), such that the level of incompleteness might not have been as high as portrayed by the results.

Figure 1: Trends in Population Growth (191 – 2020)



Source: 2000 Population and Housing Census, GSS **** projected figures***

In 2010, Ghana recorded a population of 24.6 million people with 51.2 percent being females. With a growth rate of 2.5 percent the population in Ghana is expected to double in 28 years. Figure 1 presents a picture of the changes in the population size since 1921. In view of the declining mortality and constant fertility levels until the 1980s, an average annual growth rate of 2.4 percent was recorded for the decade of 1960 – 1970. Despite the recorded declines in fertility, the population growth rate has not shown much signs of change hovering between 2.4 and 2.7 percent for the period 1984 – 2010. Due to the demographic momentum, these increases in population are expected to continue for at least the next decade.

The variation in the spatial distribution of the population of Ghana by region clearly shows an increasing percentage share of Greater Accra from 8.1 percent in 1960 to 15.4 percent in 2000 to 29 percent in 2010. Ashanti region has also shown tremendous increase in the relative share of population over the years. In 1960, the urban population in Ashanti region was 16.4 percent, this increased to 19.1 percent in the year 2000 and then to 22 percent in 2010. Upper East and Upper West regions have shown significant dwindling of the percentage share of the population.

In 1960 7.0 percent and 4.3 percent of the total population resided in the two regions respectively. This reduced further to 4.9 and 3.0 in 2000 and as at 2010 their percentage share of the population within their regions had reduced to 1.8 percent and 0.93 percent respectively (See Table 1).

Table 1: Relative Share of Population in Ghana, by Region, 1960-2010 (%)

Region	1960	1970	1984	2000	2010
All regions	100.0	100.0	100.0	100.0	100.0
Western	9.3	9.0	9.4	10.2	9.6
Central	11.2	10.4	9.3	8.4	8.9
Greater Accra	8.1	10.6	11.6	15.4	16.3
Volta	11.6	11.1	9.8	8.6	8.6
Eastern	15.5	14.1	13.7	11.1	10.7
Ashanti	16.4	17.3	17.0	19.1	19.4
Brong Ahafo	8.7	9.0	9.8	9.6	9.4
Northern	7.9	8.5	9.5	9.6	10.1
Upper East	7.0	6.3	6.3	4.9	4.2
Upper West	4.3	3.7	3.6	3.0	2.8
Total population	6,726,815	8,559,313	12,296,018	18,912,079	24,658,823

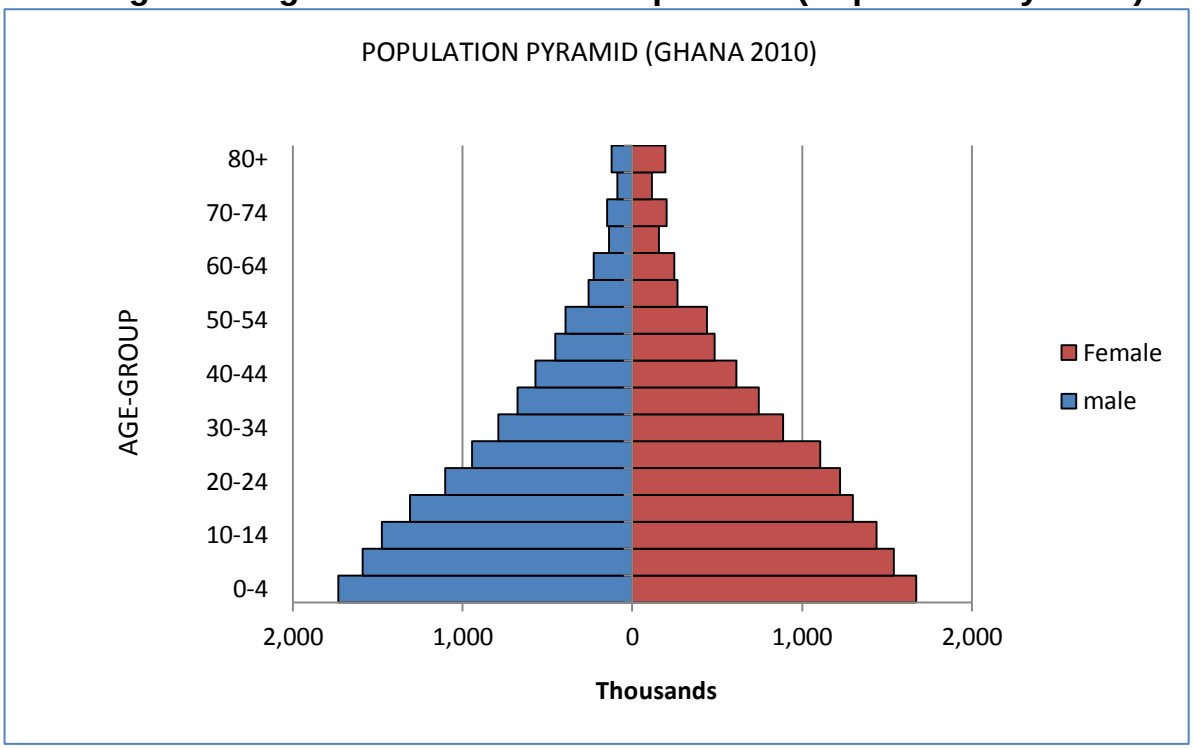
Source: NPC Population Distribution and Urbanisation Papers & Census Results, 2010

2.2 Population Age-Sex Structure

The population structure of Ghana, typical of sub-Saharan Africa, is predominantly youthful. Since 1960, the population aged 10 – 24 has increased steadily both in terms of proportion and in absolute numbers from 1,813,279 in 1960 to 3,806,500 in 1984 to 5,656,258 in 2000 to 6,381,759 in 2005 and is estimated to reach 8,010,957 by 2015. This situation is the direct consequence of high fertility and declining mortality of past years. At a current total fertility rate of 4.0, coupled with a low contraceptive usage of 17 percent for modern methods and low educational attainment among women in particular; Ghana has the potential for further high population growth despite the decline in fertility.

The population pyramid of Ghana in Figure 2 has a broad base which clearly indicates the heavy concentration of Ghana's population in the younger ages (below 15 years). Those in the age range from 15 – 64 years carry the burden of working for themselves and the non working age group. This results in a high dependency ratio of 75.6 percent in 2010, which usually leads to low savings and poor living standards.

Figure 2: Age-Sex Structure of Population (Population Pyramid)



Source: Ghana Population and Housing Census, 2010

Table 2 shows that, the proportion of the population aged below 15 has decreased consistently from 46.9 percent in 1970 to 38.3 percent in 2010, and is expected to decrease further to 35 percent by 2020. Correspondingly, the proportions aged 15-64 and 65 and above have increased from 49.4 percent and 3.6 percent respectively in 1970 to 56.9 percent and 4.7 percent in 2010. The gradual transformation of the youthful population age structure is attributed to falling fertility levels and improvement in life expectancy.This depicts a country that is moving from the first stage of the demographic transition where both birth and death rates are high to the second stage of low fertility and low mortality.

Table .2: Proportion of Population within the Various Age Groups 1960 -2020

Age Group	1960	1970	1984	2000	2010	2015*	2020*
0 – 14	44.6	46.9	45.0	41.3	38.3	37.0	35.0
15 – 64	52.3	49.4	51.0	53.4	56.9	59.0	61.4
65+	3.2	3.6	4.0	5.3	4.7	4.0	3.6

Source: Population Censuses 1960, 1970, 1984, 2000, 2010 ****Projected figures***

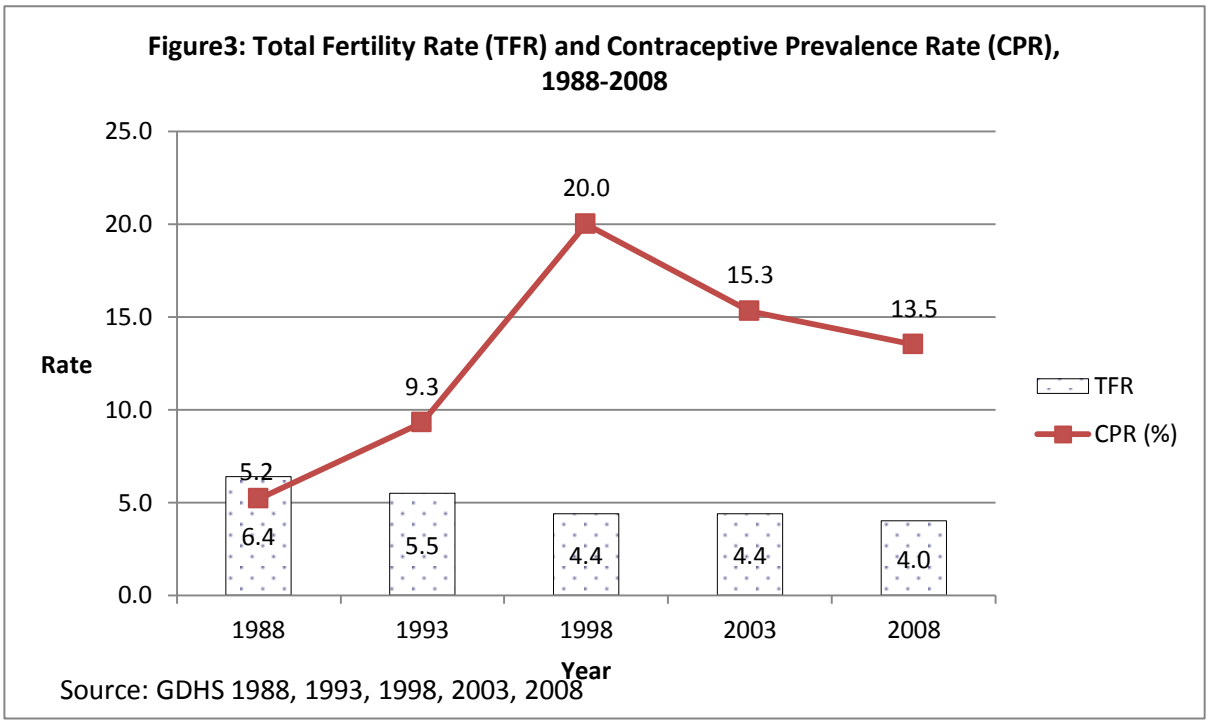
This means there is roughly one dependent person (under 15 or over 64 years old) for every economically active adult compared to about 2 adults per dependent in more developed countries. The need to provide for economically dependent persons puts pressure on the resources of the government and individual households. The ability to care for the dependent population depends on the structure and stability of the economy and the income levels and organizational abilities of the population. There are indications of a demographic transition as levels of fertility and mortality declines and it is important that interventions are put in place to enable the country reap the dividend.

2.3 Fertility

Available evidence from the various Ghana Demographic and Health Surveys (GDHS) indicate clearly that the fertility behavior of Ghana's population is changing. The average Ghanaian woman marries at the age of 19 years, has her first child a year later and has an average of 4 children in her lifetime. The Total Fertility Rate (TFR) in Ghana declined from 6.4 in 1988 to 4.0 in 2008 and is one of the lowest in Sub-Saharan Africa. However, there are variations in TFR depending on a number of factors including educational status and place of residence. In Ghana, urban fertility between 2003 and 2008 was 3.1 compared to 5.6 for the rural area in 2003 and 4.9 in 2008. Furthermore, fertility among women with higher education (secondary school and above) was 2.5 compared to an average of 6.0 children for those with no education in 2008. Despite the almost universal knowledge in family planning (over 90 percent), practice of contraception remains low. As at 2008 the country's contraceptive prevalence rate was 19 percent for modern methods for all women. The use of modern contraceptives among women almost quadrupled between 1988 (5.2 percent) and 1998 (20 percent) but then dropped to 15.3 percent in 2003 and further to 13.5percent in 2008, while TFR continued to decrease. Overall,

the use of contraception has remained steady over the past five years (figure 3). Despite the declines in fertility recorded, various socio-cultural practices and beliefs tend to sustain the high levels of fertility. Further declines in TFR can be achieved if the right programmatic interventions are put in place.

Figure 3: Total Fertility Rate and Contraceptive Prevalence Rate (1988 – 2008)



2.4 Mortality

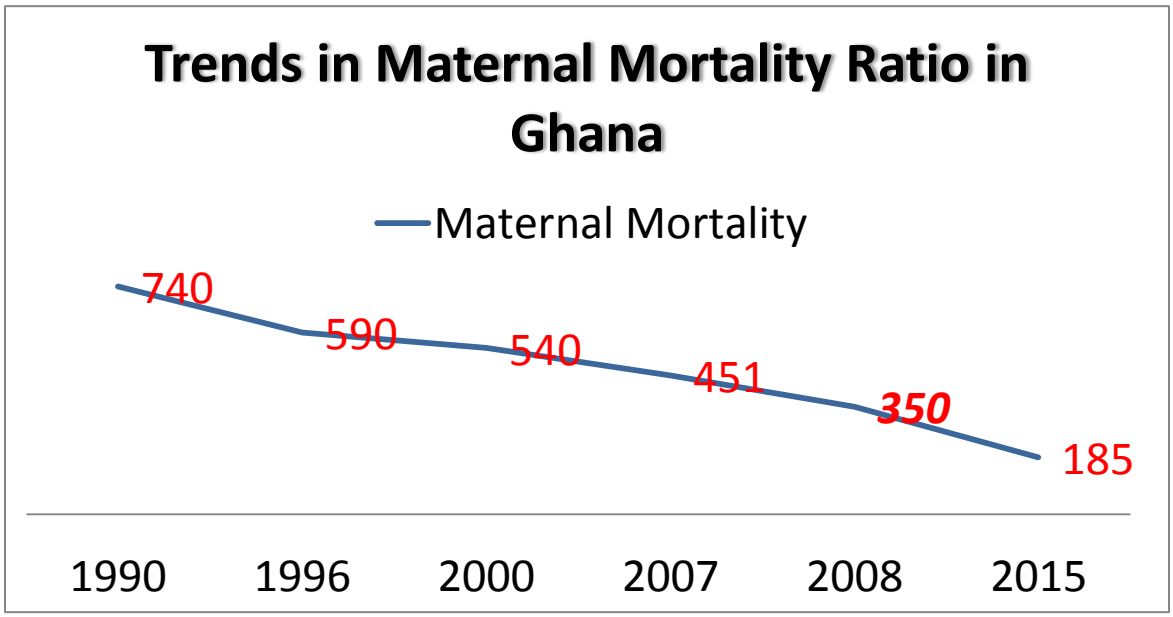
Death rates in Ghana have been steadily declining over the years as a result of a combination of factors including improvements in health conditions, increasing education and modernisation. In 2007 Life expectancy was estimated at an average of 59 years (57 years for males and 60 for females). According to the World Fact Book, 2011, the life expectancy at birth for the total population stands at 61 years (59.78 years for males and 62.25 years for females).

Maternal and childhood mortality rates in general are often used as broad indicators of social development and as specific indicators of a population's health status. In Ghana, mmaternal mortality has been high at a national average of 451 deaths per 100,000 live births (Ghana Maternal Health Survey, 2007), although a maternal mortality rate of more than 700 has been

recorded in studies carried out in some districts, particularly in Northern Ghana in the early 1980s. According to revised UN estimates in 2008, Ghana has a maternal mortality rate of 350 deaths per 100,000 live births (see figure 4).

Even though maternal mortality has recorded gradual declines, the slow pace of decline is not adequate enough for Ghana to achieve the Millennium Development Goal (MDG) 5 target of reducing maternal mortality by 75 percent by 2015. To achieve this Ghana's maternal mortality has to reduce to 185 or less by 2015. Socio-economic and cultural factors are mainly responsible for the low utilization of available maternal health services.

Figure 4: Trends in Maternal Mortality Ratio in Ghana (1990 – 2015)

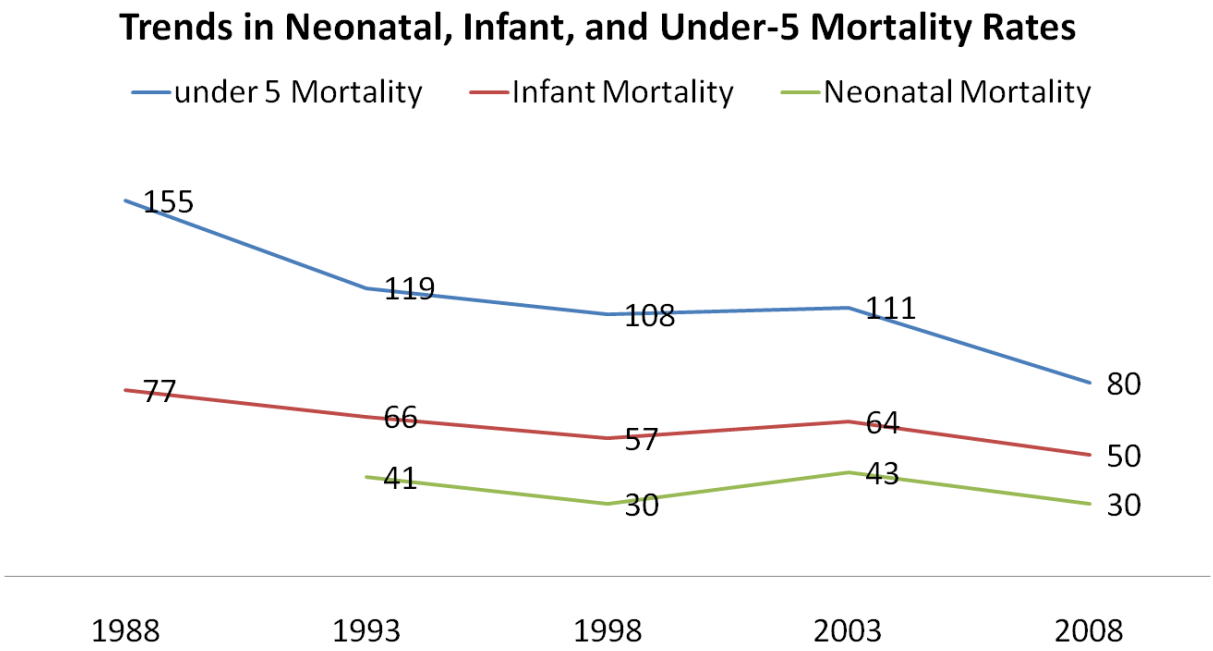


Source: GHS, 2010

In addition, meonatal, infant and under-five mortality rates have dropped substantially since 2003. Infant mortality declined from 77 per 1000 live births in 1988 to 66 in 1993 and 57 in 1998 but rose to 64 in 2003. Currently, infant mortality rate in Ghana is 50 per 1,000 live births. Under-five mortality has shown a similar trend, declining from 155 in 1988 to 119 in 1993, 108 in 1998 and then rising to 111 in 2003 with slightly higher rates for males than for females and further declining to 80 per 1,000 live births in 2008. This means that 1 in every 20 Ghanaian children die before reaching age one, and 1 in every 13 dies before his fifth birthday. Even though the country has experienced declines in infant and child mortality as illustrated in Figure 5 below, the current record of infant and child mortality is still considered high and this decline

has to accelerate if Ghana is to achieve MDGs 4. Government therefore has to strengthen and scale up existing programmes and strategies to reduce mortalities drastically in order to meet this development agenda.

Figure 5: Trends in Neonatal Infant and Under-5 Mortality Rates (1988 – 2008)



Source: GHS, 2010

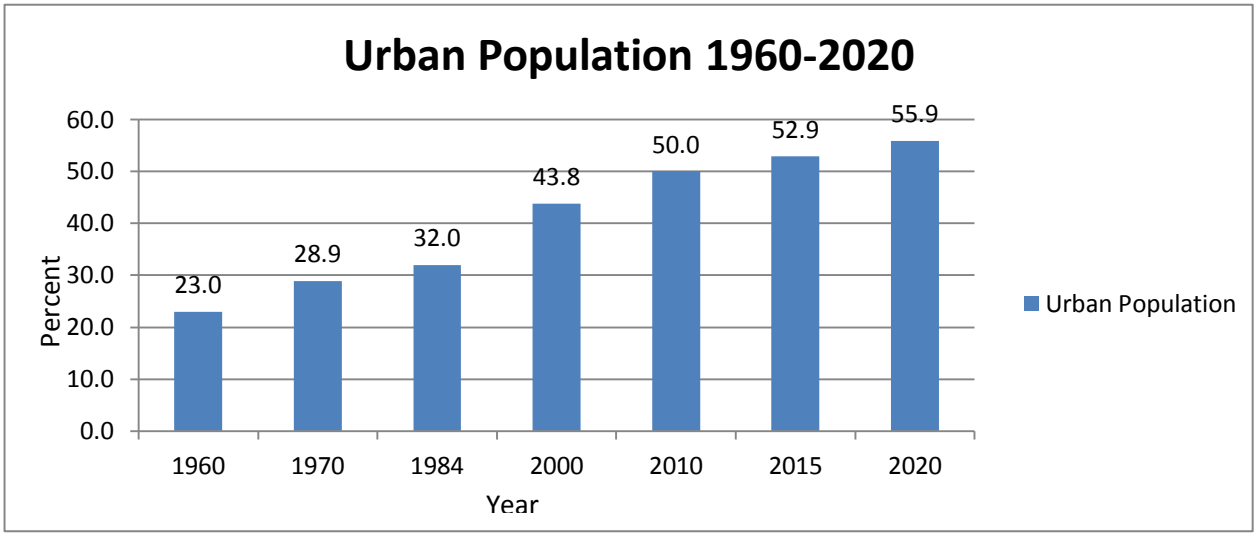
2.5 Urbanization

Urbanization has been identified as an important indicator for socio economic development. Studies have shown that across countries and over time, as the urban share of the total population rises, the overall (urban and rural) poverty rate tends to fall. This effect is transmitted largely through higher economic growth associated with more rapid urbanization rather than through re-distribution.

Over the past four decades Ghana has experienced rapid growth of the urban population. According to the census reports in Ghana, the proportion of the population that is urban increased from 23.0 percent in 1960 to 43.8 percent in 2000. It further increased to 50 percent in 2010 (see Figure 6). It is estimated that by 2020 the urban population would have increased

to 55.9 percent. At this prevailing rate of increase, urban areas in the country are expected to absorb more than half of the country's population growth over the coming years through natural increase while at the same time drawing in some of its rural population.

Figure 6: Trends in Urban Population (1960 – 2020)



Source: 2000 PHC Report, 2010 PHC Results GSS

From 1960 to 2010, all but three regions had a consistent increase in the urban proportion of their population (Table 2). These three regions – Western, Central and Greater Accra recorded declines in the proportion of their urban population in 1984 but recovered in 2000 to levels over and above those of 1970. Overall, Ghana has seen an increasing proportion of its urban population relative to the rural. This suggests that with time, Ghana's population would be more urban than rural. A case in point is the Greater Accra Region, the most urbanized region in Ghana, in which the proportion of urban population increased from about 73 percent in 1960 to 85 percent in 1970, declined to 83 percent in 1984 then went as high as almost 89.2 percent in 2010. Similar changes occurred in the Western and Central regions. In the remaining seven regions, the proportion of urban population consistently increased. The Ashanti Region has long been the second most urbanized region in Ghana after Greater Accra (Table 3). In fact, in 2000, the Ashanti Region stood with Greater Accra Region as the only regions that had a relatively higher urban than rural population. In contrast, the Upper West Region stands out as the least urbanized region in Ghana, as per the 2010 Population and Housing Census,

Table 3: Trends in Urbanization, by region in Ghana, 1960-2010 (%)

	1960		1970		1984		2000		2010	
Region	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
Western	24.7	75.3	26.9	73.1	22.6	77.4	36.3	63.7	41.7	58.3
Central	28.0	72.0	29.1	70.9	28.8	71.2	37.5	62.5	47.1	52.9
Greater Accra	72.6	27.4	85.3	14.7	83.0	17.0	87.7	12.3	89.2	10.8
Volta	13.1	89.9	16.0	84.0	20.5	79.5	27.0	73.0	33.7	66.3
Eastern	21.1	78.9	24.6	75.4	27.7	72.3	34.6	65.4	43.7	56.3
Ashanti	24.9	75.1	29.7	70.3	32.5	67.5	51.3	48.7	57.5	42.5
Brong Ahafo	15.6	84.4	22.1	77.9	26.6	73.4	37.4	62.6	55.5	44.5
Northern	13.0	87.0	20.4	79.6	25.2	74.8	26.6	73.4	29.8	70.2
Upper East	3.9	96.1	7.3	92.7	12.9	87.1	15.7	84.3	22.1	77.9
Upper West	5.0	95.0	6.7	93.3	10.9	89.1	17.5	82.5	16.3	83.7
All regions	23.1	76.9	28.9	71.1	32.0	68.0	43.8	56.2	50.0	50.0

Source: NPC Population Distribution and Urbanisation Papers & Census Results, 2010

Regions that consistently have a higher proportion of the country's population are not restricted to one ecological zone. At the same time, regions which have lost some proportion of their population are also not confined to any one particular ecological zone. For example, the Greater Accra and Western regions are within the coastal zone; Ashanti and Brong Ahafo are in the forest middle belt/zone and Northern Region is in the northern savannah but they all have registered some gains in their respective share of total population. In the same vein, regions that recorded losses straddle the three ecological zones: the Central Region and parts of Volta Region are found within the Coastal zone; the Eastern Region is in the middle belt while the Upper East and Upper West are located in the northern savannah ecological zone. This shows that within one particular ecological zone, the conditions that favour or discourage higher population concentrations vary. This situation could be attributed to the migration of young men and women to the urbanized regions specifically Greater Accra and Ashanti regions in search of better opportunities. With a majority of Ghanaians now living in urban areas, and the number of urban dwellers increasing, Government needs to put in place effective policies that harness the opportunities that urbanization presents while dealing with the challenges.

2.6 MIGRATION

Ghana's contemporary migration patterns are both complex and dynamic and like all other parts of the world. It is estimated that there is one migrant in more than 43 percent of all households

in Ghana as at 2005/2006. During the 1960's as a result of relative economic prosperity, Ghana became the destination of choice for many migrants from neighbouring West African countries. This was as a result of the development of gold mines and cocoa farms in the southern regions of the country. Ghana attracted mostly male migrants and other British and French colonies resulting in a net migration status. This trend was reversed in the late 1960's with the onset of economic decline and political instability and Ghana quickly became a net exporter of migrants. This situation was further aggravated by economic deterioration in the 1970's which led to the wide spread emigration of skilled workers and professionals particularly from the health and education sectors to other African and European countries. By the 1980's, a culture of emigration had taken root with substantial numbers of unskilled and semi–skilled workers also emigrating. Cote d'ivoire and Nigeria became the major migration poles for many Ghanaians during this era.

In Ghana, internal migration particularly from the north to the south has been practiced in Ghana for several decades, with historical antecedents. Until recently this pattern of north-south migration was male-dominated, however in recent times this pattern has changed with more female adolescents, migrating to urban centres in the country. Population censuses in Ghana since 1960 have shown that six regions namely Central, Eastern, Volta, Northern, Upper East and Upper West have largely been net out migration regions with the three northern regions having the highest out migration rates.

Data on immigrants in Ghana is not very reliable. In recent years although emigration from Ghana has increased at a faster rate than migration, Ghana still remains an important destination for migrants and refugees from other parts of Africa. According to recent census-based estimates, the migrant population constitutes more than 7 percent of Ghana's total population. The majority of immigrants to Ghana come from other ECOWAS (Economic Community of West African States) countries. In 2007, Ghana hosted the largest refugee population in the West African sub-region. In recent times, tangible economic benefits that have been derived from such migration as a result of the remittances from Ghanaians living abroad was estimated at US$2.14 billion in 2010. There are also un-recorded transfers from abroad that go through friends and relatives directly to households. These remittances play a very important role in improving livelihoods in migrant households and in general reducing poverty.

Chapter Three: Integration of Population into National Development Frameworks

3.0 Introduction

Development is linked in various ways to population change. The transformation in demographic regimes from high to low death and birth rates—the demographic transition— can be added to the list of structural changes constituting development: indeed, in terms of its direct effect on human well-being and its social and economic implications, it is arguably the most important of those changes (McNicoll, 2003). Thus understanding the complexities of population change and integrating this into development planning is essential to sustainable development.

Integration of Population Factors in Ghana

Realising the importance of population in all planning exercises, Ghana adopted an explicit and comprehensive policy on population in 1969, the third in sub - Saharan Africa after Mauritius (1958) and Kenya (1965). This policy recognised the negative effects which unregulated population growth and distribution could pose to individual and family welfare and the nation's efforts at social and economic development. The 1969 Population Policy indicated that population policies and programmes were to be developed as organic parts of social economic planning and development activity.

Twenty five years after this policy was first promulgated the country's rate of population growth still remained at an unacceptable high level and the population factor continued to act as a serious impediment to the country's march towards economic modernization, sustainable development and eradication of poverty. This, in addition to other emerging issues, led to the revision of the 1969 policy in 1994. The revised population policy aimed to improve the quality of life of the population. Specifically, population issues were to be systematically integrated in all aspects of development planning and activity at all levels of the administrative structure. Thus development issues such as education, health, environment, agriculture, governance and others were to be informed by appropriate assessment of population factors.

The first medium–term development plan (1997 - 2000) based on vision 2020 was aimed at making Ghana a middle – income country in 25 years. Subsequent development frameworks

including the Ghana Poverty Reduction Strategy 2003 – 2006 (GPRS I) and the Growth and Poverty Reduction Strategy 2006 – 2009 (GPRS II), represented comprehensive policies, strategies, programmes, and projects to support growth and poverty reduction. They sought to ensure that all Ghanaians irrespective of their socio-economic status or where they reside had access to basic social services such as health care, quality education, potable drinking water, decent housing, security from crime and violence, and the ability to participate in decisions that affect their own lives. The GPRS I was initiated as a condition for development assistance under the IMF -World Bank – supported Heavily Indebted Poor Countries (HIPC) debt relief initiative in 2002. Under the GPRS I and GPRS II substantial progress was made towards the realization of macro economics stability and achievement of poverty reduction goals. However structural challenges also emerged, this was characterized by large fiscal and balance of payments deficit mainly as a result of fiscal over runs and external shocks including upsurge in crude oil and food prices.

The follow-on programme, the Ghana Shared Growth and Development Agenda (GSGDA), 2010-2013 is aimed at ensuring that the new growth poles are reinforced to accelerate poverty reduction without becoming enclaves. In pursuance of this mandate, the national policy framework has integrated some population factors into the policy framework. The social and economic goals cited indicated the importance of population factors in terms of achieving socio-economic development. Some of the goals cited in the framework are:

- Providing citizens with secure and sustainable jobs
- Ensuring gender equity in access to productive resources such as land, labour, technology, capital/finance and information
- Expanding access to potable water and sanitation, health, housing and education
- Embarking on an affirmative action to rectify errors of the past, particularly as they relate to discrimination against women
- Pursuing an employment-led economic growth strategy that will appropriately link agriculture to industry, particularly manufacturing
- Rehabilitating and expanding infrastructural facilities

Since the adoption of the decentralization policy in 1987, the districts have become the unit for development planning in the country. However development planning especially at the District level had not taken into consideration demographic variables in the planning process.

Integrating population and development planning requires political support and is influenced by macro-economic policies, resource allocation and human development goals. The establishment of a new development planning system and the creation of the National Population Council and the National Development Planning Commission (NDPC) by government in 1994 were all aimed at making population issues central to development. Government's establishment of planning, budgeting, monitoring and evaluation divisions in most sector agencies was therefore aimed at promoting the integration of population in the activities of the agencies. Furthermore, the NDPC also developed guidelines for the preparation of district medium-term development plans. These guidelines underpin the development of an integrated national monitoring and evaluation system and ensure that implementation of the District Medium Term Development Plans (DMTDP) are monitored. These plans have largely integrated population issues to improve the quality of life of the people.

In an assessment of some of the development plans, various population indicators such as labour force participation rates, crude death rate, and dependency ratio were included in a descriptive fashion without well articulated considerations of the effect of these on national development and what needs to be done to reduce their adverse effects. In view of this, the NPC in collaboration with the Kwame Nkrumah University of Science and Technology (KNUST) and with funding from Government and the United Nations Population Fund (UNFPA) developed fifteen training modules on various sectors including health, education, housing, water and sanitation etc. to facilitate the integration of population factors into development planning. The modules are being used to build the capacity of district assembly staff to enable them in practical ways integration population concerns into their district development planning process.

Advocacy seminars are also organized for District Chief Executives and Regional Coordinating Directors to solicit their support for the programme. The modules use Microsoft Excel in analyzing and projecting future needs of the population. They examine in general terms the dynamic links among population, economic development and social needs. It is used to determine the development needs of a particular area based on the structure of the population. It has been used as an advocacy tool to sensitize politicians at the district level in the allocation of resources for population activities.

The use of the integration modules makes planning easier and more realistic. The sensitization and involvement of the administrative heads and coordinators in the training facilitated the utilization of the modules. One of the main factors hindering the use of integration analysis in development plans is scarcity of planning personnel with the requisite skills. In order to achieve the population policy objectives there is the need to train a large body of personnel, particularly district planning officers, in integration analysis. The long-term policy is to incorporate integration analysis into development/economic studies curricula, particularly at the tertiary level.

Chapter Four: Population Policies and Programmes

4.0 Introduction

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

4.1 Education

Ghana has since independence made significant strides in the educational system. Article 25 (1) of the 1992 Constitution of the Republic of Ghana endorses educational rights by stating that all persons shall have the right to equal educational opportunities and facilities. In recognition of this right, the government introduced the Free Compulsory and Universal Basic Education (FCUBE) in 1996 to expand access to good quality education and to promote efficient teaching and learning. Section 5.5.1 of the 1994 revised population policy states that "subject to the availability of resources, free and compulsory universal basic education shall be provided. Policies and programmes that encourage girls to continue schooling up to at least the secondary school level will be vigorously pursued". Furthermore, section 5.5.2 of the population policy states that special programmes shall be developed to improve low enrolment rate and reduce the high school drop rate through practical and technical training that will provide ample opportunities for gainful self-employment.

Formal education in Ghana begins with six years of primary education (ages 6-11), three years of Junior High School (ages 12-14) and three years of Senior High School (ages 15-18), concluding with the tertiary level of universities, polytechnics and other higher level institutions. The number of children of primary school-going age (6-11 years) doubled in three decades from 1.5 million in 1970 to 3.1 million in 2000. (See Table 3). Over the same period, the number of children of JHS age increased from 595,000 to 1.3 million and from 476,000 to 1.6 million in Senior High School. This doubling of the school going age population is the outcome of high population growth in the period concerned.

Table: 4 Changes in Ghana's population of school-going age, 1970-2000

Year	Primary (6-11)	Junior High School (12-14)	Senior High School (15-18)

1970	1,533,734	594,618	476,101
1984	2,166,482	910,139	761,101
2000	3,154,146	1,321,159	1,583,615

Source: State of Ghana Population Report, 2003

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

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

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

In 1987, government introduced the Sciences, Technology, Mathematics and Education (STME) clinic for to promote the interest of girls in Science Technology and Mathematics education. It was also to enable girls interact with women scientists and technologists. The clinics were decentralised to the district level in 1997 and has resulted in an increase in the number of girls pursuing science and technology related courses in secondary schools as well as the universities.

One of the goals of the population policy is to increase the proportion of females entering and completing at least Senior High School. In line with this goal, the policy's education target is to increase the proportion of 15-19 year old females with secondary education and higher by 50 percent by 2005 and up to 80 percent by 2020. In 1997, the Ministry of Education (MOE) established the Girls' Education Unit of the Ghana Education Service (GES) to increase the enrollment of girls in schools to equal that of boys by the year 2005. The Unit was also tasked to reduce the dropout rate for girls from 30 percent to 20 percent in the primary schools and from 29 percent to 15 percent in the JHS. Considerable progress has been made in this area. For example, while in 1990/1991, girls' enrolment at the primary level was 45 percent, the percentage in 2000/2001 was 47.2 percent. That of JHS went up to 45.3 percent in 2000/2001 from 40.8 percent in 1990/1991.

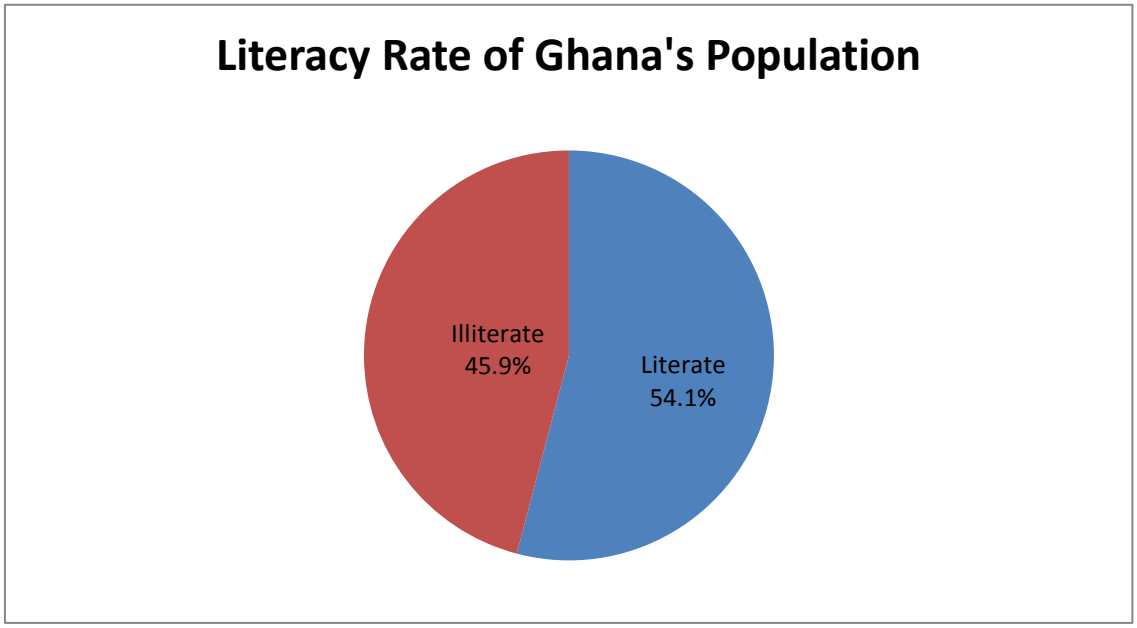
In addition, several programmes were undertaken under the affirmative action policy to bridge the gap between males and females. The University of Ghana has a policy to encourage the enrolment of females at the University. The cut off grades for females are lowered to give more room for female students entering the university. During the last admission process, the aggregate cut off point for admission to the university was 15 for females and 16 for males.

4.2 Literacy

In 1948, only four percent of Ghanaians had ever been to school. Despite significant improvements over the years, the situation leaves much to be desired with 42.6 percent of the population aged 6 still illiterate. Indeed, the absolute numbers of illiterate people in Ghana rose in 30 years from 3,791,762 in 1970 to 6,635,168 in 2000; representing 45.9 percent of the population (see Figure 5). This increase was partly due to high population growth rates and the inability of government to keep up with the pace of

education for such numbers (SGPR, 2006). The decline on illiteracy is a result of increases in school enrolment.

Figure 7 Literacy rates for Ghana, 2000



Source: State of Ghana Population report (2003)

The 2000 Population and Housing Census results show that illiteracy is more prevalent among adult Ghanaian females (54.3 percent) than males (37.1 percent). This low level of literacy among females has far reaching consequences for demographic processes such as fertility behavior, mortality prevalence as well as sustainable development. Illiteracy among adult females tends to be associated with high fertility and high maternal mortality and low level of empowerment. Table 5 indicates that a high rate of illiteracy exists among females. This huge deficit is among rural and urban poor women which deny them full participation and partnership in economic and social issues in the country.These tendencies make it difficult for women to utilize their full potential in the development process**.**

Table 5 Literacy rates for adults, 15 years and over by sex

Literate 15 years and over	Total (%)	Male (%)	Female (%)

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

Source: Population and Housing Census (2000)

To address this, the government, in the mid 1990s, through the Non Formal Education Department (NFED) introduced the functional literacy programme in Ghana. The functional literacy programme aimed to increase the number of Ghanaian adults (15-45 years) particularly women and rural poor to acquire literacy and functional skills. The core project design rested on teaching basic literacy and functional skills to adults in 15 Ghanaian languages. In addition, the project aimed at strengthening the radio broadcasting component as well as the broader literate environment in order to sustain project outcomes in the long run. In addition, participating groups were to be encouraged to undertake Income Generating Activities (IGAs) such as animal rearing, palm oil processing and mat weaving. The project was also to deliver a pilot in English literacy based on demand. When the first phase of the programme ended in 1997, it had enrolled 1.3 million adults and trained them in basic literacy and functional skills (in areas such as health, nutrition and sanitation, and environmental cleanliness.

The second phase of the programme was launched in 2000. Its aim was to educate about one million non-literate adults, especially rural and poor women by 2004. In December 2004 the period was extended to December 2006.The project recorded some achievements. Sixty percent female participation was recorded against 40 percent for males. It also resulted in behavioral changes and better awareness in areas such

as health and child care, schooling of children and decision making and participation. The programme targeted women in the productive age group and in the rural areas. In expanding the programme, it is recommended that more efforts should be made to provide access to credit and find markets for the produce of their learners. District Assemblies should also be encouraged to provide support in diverse ways to the functional literacy programme for the sustenance of the programme.

4.3 Labour Force and Employment

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

In 1984, the active population (15-64 years), which constitutes the bulk of the labour force, was 6.3 million (51.2 percent of the population). This increased to 10.1 million in 2000 (53.4 percent of the population) and to 14 million (57 percent) by 2010. By inference, the age dependency ratio reduced from 95.3 percent in 1984 to 87.3 percent in 2000 and to 75.6 percent in 2010. The increased labour force size and a declining dependency ratio suggest fertility reduction, which is shown by the reductions in total fertility rate. In spite of the observed decline in both dependency ratio and fertility in the country, unemployment has shown some increases during the same period. The 2003 State of Ghana Population Report, quoting 1984 and 2000 census figures, reports that, unemployment in the country increased from 2.5 percent of the labour force in 1984 to 8.6 percent in 2000, with the number of jobless persons growing from 158,000 in 1984 to 870,000 in 2000. The number of jobless people could even be higher now. In 2002

when government undertook the registration of the unemployed, it recorded 903,437 persons (58 percent male and 42 percent female) actively looking for jobs. More than half (52 percent) of registered unemployed persons had no skilled trade or training, while close to a third are unable to read at all, suggesting that they have little or no education. Such unemployed persons therefore become ineligible for employment in jobs requiring some training or skills. The aim of this exercise was to assess their skills for training. Although the Ministry of Manpower, Youth and Employment (MMYE) reports of some training programmes for those with little or no skills, not much is known of where those trained are working and whether the training programmes have been sustained since 2002. The unemployed situation in Ghana, therefore suggests that apart from there being increases in the number of persons unemployed or underemployed, the level of education and training of the unemployed is also quite low. This means that the issue of unemployment may be more that of training/education but also lack of absorptive capacity.

4.4 Reproductive health

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

The country's organized Maternal and Child Health (MCH) activities started in the 1920s and by 1972, there were 416 institutions offering services to mothers and children. In

1970, the government established the Ghana National Family Planning programme (GNFPP) under the Ministry of Finance and Economic Planning since family planning was a fundamental human right of individuals and couples. The MCH and GNFPP were later merged under the Ministry of Health to become MCH/FP.

After the ICPD, there was a move from MCH/FP to a broader RH setting. To ensure effective RH care of the population, a number of policies were developed to guide implementation of programmes such as the National Reproductive Health Service Policy and Standards (that provides explicit direction, framework and focus to training and service provision of RH) and National Reproductive Health Service Protocols (which provide standard guidance to service provision covering all components of RH). The Reproductive Health Strategic Plan (2007-2011) provides the framework for achieving the vision of improving health status and reduces inequalities in health outcomes of all people living in Ghana. In addition, the Safe motherhood programme was started in 1987 as a component of the larger reproductive health programme.

The national (RH) policy recommends a minimum of four visits during pregnancy. In 2009, 92.4 percent of expected pregnancies were registered for antenatal, an increase from 88.7 percent in 2005. About 82 percent of registrants made at least four visits in 2009. The free maternal care services introduced by the government with support from UK Department for International Development (DFID) have improved access to maternal health services significantly.

In Ghana, antenatal Care (ANC) Services are provided by public health facilities and other private agencies including, Christian Health Association of Ghana (CHAG) Planned Parenthood Association of Ghana (PPAG) and private healthcare facilities including private maternity homes. In places where these health facilities are not available, trained Traditional Birth Attendants (TBAs) are supported to provide ANC services within their capabilities in the communities. The maternal mortality ratio reduced markedly from 740 to 350 per 100,000 live births from 1990 to 2008 while

under-five mortality reduced modestly from 110 to 80 per 1000 live births within the same period. These achievements were accrued from the various policies, strategies and programmes put in place.

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

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

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

The 1994 population policy of Ghana recognizing the importance of family planning to population management had an objective to ensure accessibility to, and affordability of family planning means and services for all couples and individuals to enable them regulate their fertility and to provide fertility management programmes that will respond to the needs of sterile and sub-fertility couples to achieve satisfactory self-fulfilment.

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

Barriers to the use of family planning, exists among various categories of people such as, service providers, community and family members, and also among individuals. Misconceptions and the barriers could be employed as opportunities as new strategies in addressing the gaps in family planning implementation. According to the 2008 GDHS, the main reasons for not intending to use contraception in the future among currently married women are;

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

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

4.5 Age at Cohabitation or Marriage

Marriage marks the point in a woman's life when childbearing becomes socially acceptable in Ghana. Fertility is directly determined by a number of factors which in turn

are affected by many social, cultural economic, health and other environmental factors. Characteristically, developing countries have high poverty levels and this breeds lifestyles associated with high fertility because traditional societies tend to perpetuate pronatalist's cultural beliefs. These beliefs keep birth rates high and favour large families. For example, all women want to marry and many couples will like to have at least a male child.

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

Early age at first marriage is an important fertility indicator not only because it increases the length of time a woman is exposed to the risk of pregnancy but it also tends to lead to early childbearing and higher fertility. The median age at first marriage for women aged 25-49 was 19.8 years in 2008 which is a slight increase over the median age

reported from the 2003 GDHS (19.4). According to the report, across all age groups, the proportions of women married are larger than the proportions of men married.

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

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

4.6 Opportunities for Birth Spacing and Reinforcing the Value of Small Families

The overriding objective of the government of Ghana's economic development programme is poverty reduction and general improvement of the welfare of all Ghanaians. Among other things, the revised population policy aims at reducing TFR from 5.5 in 1993 to 5.0 by the year 2000, and 4.0 by 2010. The policy accordingly aimed at increasing CPR to 15 percent for modern methods by the year 2000 and 28 percent by 2010. The policy proposes strategies to encourage small family sizes. Section 5.6.8 of the population policy states that "systematic attempts will be made in both public and private sectors to discourage economic and financial polices that encourage large family sizes". Section 5.6.9 (b) also indicates "the number of paid maternity leaves will be

limited to three during the entire working life of those affected and no payment will be made in respect of any number of leaves beyond this limit." However, this and other interventions put in place in the policy to address large family sizes are not being implemented.

It is worth noting that the country has made some progress in reducing fertility. The GDHS results showed a decline in (TFR) from 6.4 births per woman in 1988 to 5.5 in 1993, to 4.6 in 1998, to 4.4 in 2003 and 4.0 in 2008 indicating that, there was a minimal drop between 2003 and 2008. Although fertility is declining in Ghana, it is still high, particularly among some geographic groups. For example, the regional disparities range from as low as (2.5 per woman) in the Greater Accra Region to as high as (6.8 per woman) in the northern regions. The increase in human numbers is a source of concern to policy makers and planners because of lack of commensurate increase in available resources, which affect the quality of life of the people.

According to the 2008 GDHS report, about 35 percent of married women have an unmet need for family planning. Unmet need for child spacing is higher than the unmet need for limiting children (23 percent and 13 percent) respectively. However, between 2003 and 2008 CPR declined from 19 percent to 17 percent. This has also been a cause for worry among policy makers. Also, only 40 percent of demand for family planning is currently being met, implying that the needs of more than one in two Ghanaian women are currently not being met.

4.7 Access to Primary Health Services

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

of health care delivery in Ghana shall be intensified. Maximum community participation in the formulation and of health services shall be promoted.

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

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

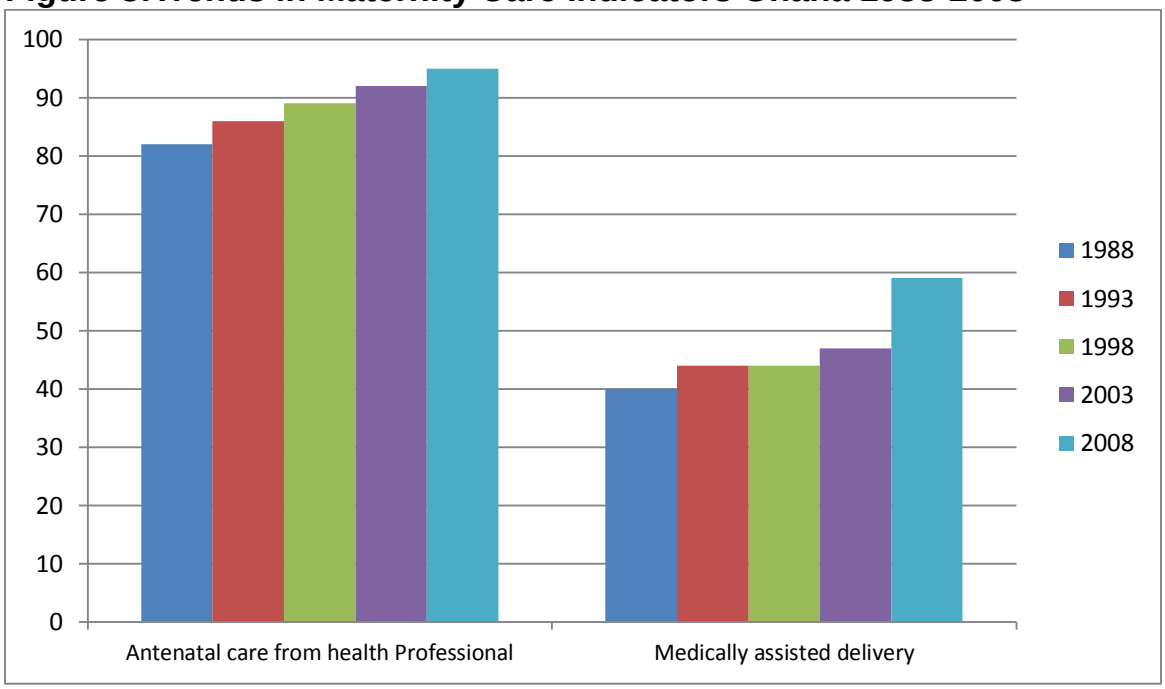
The 2008 GDHS shows 95 percent antenatal care was received from a health professional. Differences exist in the use of antenatal care services between women in the urban and rural areas and those with different educational levels. Health professionals provide antenatal care for 98 percent of mothers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

4.8 Delivery and Postnatal Care

With the introduction of free maternity services and the introduction of the CHPS compounds which are closer to the people, some barriers for accessing skilled maternity care have been removed. Fifty seven percent of deliveries now occur in health facilities (48 percent in the public sector as against 9 percent in the private

sector). Home births are much more common in rural areas (58 percent) than in the urban areas (17 percent). Postnatal care helps prevent complications after childbirth. More than two-thirds of women now receive a postnatal check-up within two days of delivery. However 23 percent of women do not receive any postnatal care within 41 days of delivery.

Figure 8:Trends in Maternity Care Indicators Ghana 1988-2008



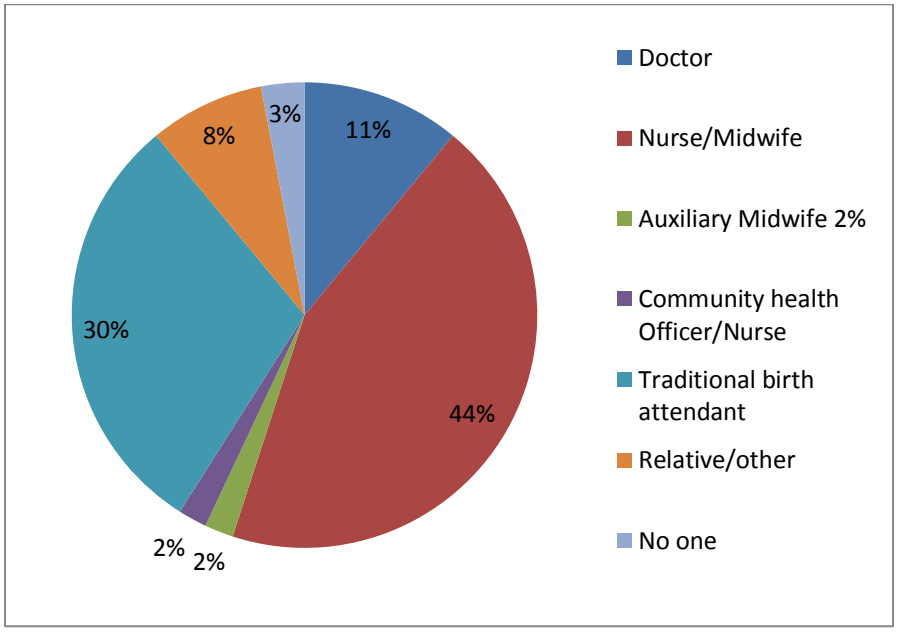
Source: 2008 Ghana Demographic and Health Survey

Figure 8 indicates that there was an improvement in antenatal care from a health professional from 82 percent in 1988 to 95 percent in 2008. There has therefore been a marked improvement in antenatal care coverage in Ghana over the past 20 years. Also, medically assisted deliveries improved from 40 percent in 1988, 44 percent in 1993 and 1998 and then shot up to 59 percent in 2008.

Figure 9 shows the percentage of type of assistance during delivery for births in the 5 years before the 2008 Ghana Demographic and Health Survey. More than half (59 percent) of births were delivered by a skilled provider (doctor, nurse, midwife, auxiliary

midwife and community health officer/nurse. Of the remainder, a higher proportion of births were assisted by TBAs.

Fig 9: Assistance during Delivery



Source: 2008 Ghana Demographic and Health Survey

4.10 Adolescent reproductive health

According to the 2008 GDHS one in ten teenagers has already had a child and another 3 percent are pregnant with their first child. Births to teenage mothers (age 15-19) have been found to have the highest infant and child mortality in Ghana (GSS and MI, 1994 and 1999). The 2007 Ghana Maternal Health Survey indicates that 15 percent of all maternal deaths in Ghana are to adolescents. Out of the total 889 maternal deaths recorded in 2009, 72 were found to be adolescents. This may be due to the fact that these young mothers are more likely to experience complications during pregnancy and delivery than older mothers, resulting in higher morbidity and mortality for both themselves and their children.

According to the United Nations Population Fund (UNFPA), sub-Saharan Africa has the lowest demand (30 percent) and use (20 percent) of contraceptives among 15-19 year

olds contributing to high rates of adolescent pregnancies. Evidence from the GDHS (2008) indicates that more sexually active adolescent males than females use modern contraception (86.7 percent for males and 32.8 percent for females). This heightens the problem of adolescent pregnancies as the unmet need for contraception remains high among female adolescents. The government has strengthened efforts to curb the difficulties facing the youth in various aspects of reproductive health, through the various ministries, agencies and departments. Agencies such as Ghana Health Service (GHS), Christian Health Association of Ghana (CHAG), Planned Parenthood Association of Ghana (PPAG), help in championing the cause of adolescent health in Ghana.

4.10.1 Demographic and social factors associated with Adolescent Pregnancy

Certain socio-cultural and demographic factors continue to pose challenges in addressing the reproductive health needs of Ghana's young people. These challenges include early age at first marriage, early age at first sex, increasing indulgence in premarital sex and low use of contraception**.** Data from the Ghana Demographic and Health Surveys (1998, 2003 & 2008) show an increasing age at first sexual intercourse; marriage and childbearing. As indicated in Table 6, the age at first sex has increased over the years (from 17.5 years in 1998 to 18.3 percent in 2003 and 19.2 percent in 2008). Though the increment is gradual, the target as stipulated in the Adolescent's Reproductive Health Policy to motivate young people to increase the age of onset of sexual activity from around 12 years to over 15 years by 2010 has been achieved**.** Again, early births for the female population below 20 years (adolescents) have declined tremendously over the years (1998-2008). In 1998, early births peaked at 32 percent. This reduced to 23 percent in 2003 and further declined to 13 percent in 2008 indicating that some sexually active adolescents are postponing childbirth. These average successes have been achieved due to the strategies and effective programs being put in place by government and other stakeholders.

Table6: Demographic and Social factors associated with adolescent pregnancy

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

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

4.10.2 Policies and existing programs on Adolescent Health Promotion and Advocacy

4.10.2.1 Government of Ghana

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

The Adolescent Health and Reproductive Health Programmes in Ghana are making strides in promoting the objectives of the National Strategic plan in the health and development of young people. Youth corners and youth friendly services are being established nationwide by the GHS, CHAG and PPAG. Analysis of the progress of the regional youth corners, as reported by the annual Adolescent Health Development Programme (AHDP) 2009 shows that 129 youth corners are functioning nationwide (see Table 7). The Ministry of Health and its partners have implemented a number of

adolescent reproductive health actions recommended in the Adolescent Reproductive Health Policy. The goals of the policy (NPC, 2000) enjoin all stakeholders as well as the private sector to participate actively in the formulation, implementation, enhancement and expansion of the sexual and reproductive health programs for adolescents and young people. These programmes are found in the broad areas of education (school curriculum for basic education, and other informal settings), media campaigns, counselling, youth development, peer education and service provision. The challenge however is to ensure the translation of all policy objectives into effective programs and activities. Various NGOs have contributed and are still contributing to the promotion of adolescent reproductive health programmes and activities in Ghana. They continue to advocate for the need to put adolescent sexual and reproductive health issues constantly on the development agenda of the country.

Table 7: Number of regional persons available, trained frontline workers and functional ADH Corners, 2009

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

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

4.10.2.2 Proposed Strategies

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

4.10.2.3 Youth Development

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

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

4.10.2.4 Access to Contraceptives and Reproductive Health Care Information

Adolescents are gradually becoming more knowledgeable about reproductive health issues, as more programmes are been targeted to reach them. As indicated in Table 7, significant gains have been made over the years in the exposure of adolescents to

knowledge on safe sex and use of contraception (From 5 percent in 1998 to 6.9 percent in 2003 and 8.5 percent in 2008). Adolescents may however have concerns about the cost, confidentiality, and accessibility of family planning services that may prevent them from accessing these services from the providers.

One of the specific objectives of the AHDP stated in their 2009 report is to increase young people's access to general health services including sexual and reproductive health care in 25 percent of health facilities and outreach points by the end of the year 2006, 50 percent by the end of 2015 and 100 percent by end of year 2020. As shown in the Table 7 above, access to and utilization of health services by adolescents are very poor. Some of the Adolescent Health **(**ADH) Corners in the regions have been closed down due to inadequate availability of human, material and financial resources. The number of resource persons are said to be decreasing as a result of transfers, retirement and pursuit of education. Other offices of the youth centres as noted in report now serve as canteens and some been converted into National Health Insurance Scheme (NHIS) offices.

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

4.10.2.5 Sexuality Education

As part of the efforts being made by the Ghana Education Service (GES) towards the incorporation of sex life education into the GES syllabus, the GES should strengthen its efforts in the expansion of and diversification in the existing programmes to reach out-of-school adolescents so they could also benefit immensely from sexuality education.

This could be offered outside of school settings in order to target harder-to-reach teens and teens at higher risk of early pregnancy.

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

4.10.2.6 Research, monitoring and evaluation

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

Furthermore, the key indicators (as specified in the Standards and Tools for Monitoring Adolescent and Youth Friendly Services in Ghana) for monitoring and evaluating the impact of adolescent sexual and reproductive health programs should be strengthened. This is to allow for efficiency and effectiveness of the adolescent reproductive health programme (Section 10.0 of the Adolescent Reproductive Health Policy) All partners in adolescent health should be encouraged to present quarterly reports to the GHS so as

to enable them have an up-to-date data or progress report on all programmes in adolescent health being undertaken by non-governmental organizations.

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

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

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

4.12 Population and gender issues

4.12.1 Role and Status of Women

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

The 1994 Revised Population Policy recognises the centrality of women's role in production, reproduction and as agents and beneficiaries of socio-economic development and change. It recognises the disparities that exist between men and women in accessing basic services and economic opportunities. Again, Section 4.2.6 of the 1994 Revised Population Policy states, "measures that will be instituted by government, in collaboration with traditional authorities and other interested organizations or institutions to enhance the status of women in the society". This was to be done through a wide range of measures such as the elimination of all discriminatory laws and cultural practices which are inimical to the general well-being and self esteem of women and to promote wider productive and gainful employment for women. In addition, it sought to increase the proportion of females entering and completing at least SHS; to develop a wider range of non-domestic roles for women; and to examine the structure of Government conditions of employment and if necessary, change them in a way to minimize their pronatalist effects.

4.12.2 Economic Empowerment

Section 4.3.11 of the population policy states that, programmes will be developed aimed at the empowerment of women to increase their participation in the modern sector, engage in income-generating activities, and enhance their economic well-being generally. In Ghana, about 51.2 percent of the population are women who make up about half of the entire labour force and are significant contributors to national output growth (IFC report 2007). Most economically active women in Ghana operate in the

informal economy, where they outnumber men, and are particularly involved in various micro-enterprises and retail trade, the report states.

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

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

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

- Business Assistance fund - operated in the 1990s to provide direct lending to the SME sector. The loans were widely seen to be abused politically with most of the loans going to perceived supporters.
- Export Development and Investment Fund (EDIF) – Under this scheme, companies with export programmes can borrow up to $500,000 over a five-year period at a subsided cedi interest rate of 15 percent. While the scheme is

administered through banks, the EDIF board maintains tight control, approving all the credit recommendations of the participating banks.

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

4.12.3 Women in Governance

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

Progress in getting women to occur political positions has been slow in Ghana. Although women constitute over 51.2 percent of the population, they currently represent only 8 per cent of Members of Parliament, down from 11 per cent in the 2004 Parliament. Since 1993, the number of female parliamentarians has increased from 19 to 23 in 2005 and decreased to 19 in 2010. It is however, encouraging to note that for the first time in the history of Ghana, women, have been appointed to the highest offices of the Speaker of Parliament, Chief Justice and Chairperson of the Public Services Commission.

CHAPTER 5: FUTURE PROSPECTS AND PROJECTIONS

5.1 Introduction

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

Ghana currently experiences rapid population growth with high levels of fertility and mortality. The young age structure of the population has a high potential for a rapid expansion of the population in the future. Though surveys have shown a gradual decline in fertility levels since 1988, estimates indicate that the TFR will not reach replacement level of 2.1 live births per woman with the current level of investments. Fertility, mortality and migration levels and trends are essential information needed for planning for the future. Therefore assessing the future population and other demographic variables would reveal realities that reflect some of the development challenges facing the country. It should be noted that information on international migration are so scanty and unreliable that immigration and emigration are assumed to cancel out and are therefore not factored into projection of the total population.

This chapter presents and discusses the future prospects and projections of Ghana' population. The projections are based on the results of the 2000 Population and Housing Census (PHC) and available data from the 2010 PHC that has been released at the time of preparing this report, as well as sample surveys conducted to provide information on fertility, mortality, contraceptive usage and other indicators.

5.2 Population Change

One of the major challenges facing Ghana is reducing its high population growth rate of 2.5 percent per annum in the 2000 – 2010 intercensal period. A decrease from the 2.7 percent estimated in 2000. Projections of population growth rates using low, medium and high assumption variants put the population growth rate at between 1.54 percent per annum (low variant) and 2.4 percent per annum (high variant) for 2015. For 2020, the projected growth rate figures for low and high variants are between 1.37 percent and 2.4 percent per annum respectively. Corresponding medium variant estimates for the two projection years are 2.0 percent and 1.9 percent respectively (Ghana Statistical Service, 2005).

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

5.3 Fertility Levels

A marked reduction in fertility levels would substantially reduce the present high dependency burden imposed by the youthful age structure of Ghana's population. The high proportion of people entering the reproductive or childbearing age, which is a key factor influencing the future number of births, will eventually decrease. The fertility decisions that young people make today will determine to a large extent the demographic scenario of the country in the future. These decisions would depend on family planning information and the range of services made available to Ghanaians,

especially young people, to empower them to manage their fertility and to determine the timing and number of children they want.

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

5.4 Mortality

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

Table 8: Estimated and Projected Values of Expectation of Life at Birth

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

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

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

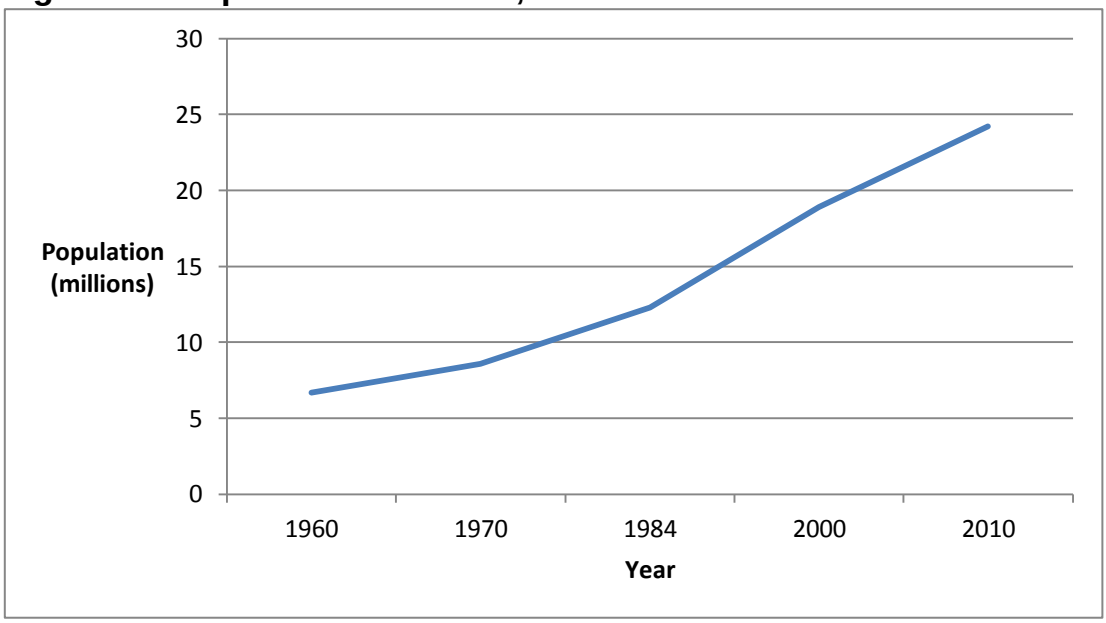
The gradual increase in expectation of life at birth corresponds to reduction in the level of infant and under-five mortality over the past two decades. Mortality among infants decreased from 77 per thousand live births in 1988 to 57 live births in 1998, increased to 64 live births in 2003, then decreased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

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

5.5 Population Size and Structure

Results of the 2010 Population and Housing Census put the population of Ghana at about 24.6 million. This implies an increase of 30.4 percent over the period 2000-2010. The trend in population growth in Ghana is shown in Figure 10 below:

Figure 10: Population of Ghana, 1960-2010



Source: Ghana Statistical Service Census Reports, 1960-2010

The Figure shows that the population of Ghana grew relatively slowly between 1960 and 1970, after which the annual additional numbers increased slightly up to 1984. Between 1984 and 2000 additional numbers increased slightly; however, the scenario during the period 2000-2010 indicates a possible stabilization or reduction in annual additional numbers in the future. If the current trend continues, the population of Ghana will stand at around 29.5 million by 2020.

The population of Ghana is young with a substantial proportion aged below fifteen years. However, over the years, evidence indicates that the age structure of the population of Ghana is changing gradually with the proportion aged below fifteen years declining. This is typical of a population that has begun the demographic transition from high to low fertility. During the transition from high to low fertility levels, populations tend to be characterized by large numbers of women and men in the reproductive ages, which lead to large numbers of children being born. Women in the reproductive ages (15-49 years) will constitute a comparatively large group in the population. The proportion of the population aged below fifteen years increased from 44.5 percent in

1960 to 46.9 percent in 1970, and then decreased to 45 percent in 1984 and 41.3 percent in 2000 and 38.3 percent in 2010. Projections indicate that the proportion the Ghana's population aged below fifteen years will continue decreasing to 35 percent by 2020. The population will remain young and therefore will maintain a high growth potential.

5.6 Urbanisation

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

Ghana exhibits one of the fastest urban growth in the world. In 1960, almost one-quarter (23 percent) of the population lived in urban areas. By 2010, half of Ghana's population lived in urban areas, and it is projected that 55.4 percent of the population will be residing in urban areas in 2015, increasing to 59.2 percent by 2020. Internal migration has been a population response to the changing social and economic conditions in the country. As the socio-economic conditions changed, so did the type of migrant and purpose of movement with an increase in female migrants. Urban centres emerged as destinations of the major structural flows of people across the country. Furthermore, urbanization is an integral part of the socio-economic transformation taking place in Ghana, which has led to the redistribution of the population in such a way as to effect more social change.

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

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

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

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

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

Chapter 6: Conclusions and recommendations

6.1 Conclusions

It is, however, observed that rapid population growth is likely to reduce per capita income growth and well-being, which tends to increase poverty. The effects of poverty become even more serious, especially where there is high rate of unemployment amongst the economically active population of a country. A major contributory factor to the high population growth is the declining but still high fertility levels which is largely responsible for the burgeoning of the young population. The young population implies an in-built population momentum for growth with projections of 25.9 million by 2020.

Ghana is currently experiencing economic growth of between 7 per cent and 14 per cent per annum. This is occurring alongside considerable backlogs in developing human capital, improving living standards, building the needed infrastructure, as well as expanding access to services such as health and education, and to energy. The transition to a more favourable demographic regime will thus remain a critical and difficult period for Ghana for some decades. The demographic transition has more or less stagnated, the challenge, therefore, is whether or not Ghana will be able to stimulate further reductions in fertility and mortality so as to take advantage of the "demographic window of opportunity". For the country to overcome its demographic challenges there is the need to integrate population variables into development planning and policies of major sectors of the economy and at all levels.

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

Many developing countries today have large proportions of their populations being youthful due to the high levels of fertility and mortality that have existed in these countries over a period. The youthful population leads to a high dependency ratio whereby the proportion of the working age population is lower compared to the number of dependents. Ghana has started the transition from high fertility and high mortality to low fertility and low mortality. This shift in the age structure creates a window of opportunity for Ghana to take advantage of the released resources for economic growth and development, thus contributing to a virtuous cycle of economic growth .This demographic transition has significant implications for labour force supply, savings and human capital. As the working age group (15-64 years) increases and the ratio of dependants decline as more people move into the working age population with fewer dependants. Women also enter the labour market as family sizes decline. The working age group therefore tends to have a high economic output and savings as improved health and life expectancy makes savings attractive. The longer life expectancy changes the way people live; they invest in their health and education as well as those of their children and create an environment for families to enjoy a higher standard of living.

6.2 Recommendations

Despite the checkered results, Ghana is convinced that with continued political will, adequate funding, and integrated package of services, we will record better progress in our population and development indicators. The above mentioned situation can be improved through

- ***Improve sexual and reproductive health and rights***

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

- ***Increase sexuality education***

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

- ***Ensure Universal Primary Education***

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

- ***Provide micro credits to youth and women***

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

- ***Create employment opportunities***

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

- ***Increase resource allocation to population sector***

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

ANNEX A:

Some key Demographic Indicators of Ghana

Indicator	Indicator Level		Source
	2000	2010	
Total Population	18,912,079	24,658,823	2010 Population and Housing Census. Results
Intercensal Population Growth Rate (percent)	2.7	2.5	"
percent of Population Female	50.5	51.2	"
percent of Female 15-49 years	47.3	50.3	
percent of Population under 15 years	41.3	38.3	"
percent of Urban Population	43.8	50	"
Sex Ratio (percent) – males per 100 females	97.9	95.0	"
Dependency Ratio	71.0	75.6	"
Population Density	79.3	103	"
HIV/AIDS Prevalence Rate (percent)	2.3	1.7	HIV&AIDS Sentinel Survey Report, 2010
Total Fertility Rate	4.4	4.0	Ghana Demographic and Health Survey, 2008
Infant Mortality (per 1,000)	64	50	"
Under-Five Mortality (per 1,000)	111	80	"
Contraceptive Prevalence Rate (Modern Method in percent)	16.6 (currently married women) 13.5 (all women)		Ghana Demographic and Health Survey, 2008

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