

Memorandum

Date April 8, 1981

From Richard S. Monteith, M.P.H., Program Analyst, Program Evaluation Branch,
Family Planning Evaluation Division, Center for Health Promotion and Education
(CHPE)

Subject Foreign Trip Report (AID/RSSA): Ghana, March 8-24, 1982—Preparation of FY
1984 Contraceptive Procurement Tables and Assistance to the Ministry of Health

To William H. Foege, M.D.
Director, Centers for Disease Control
Through: Horace G. Ogden
Director, CHPE *HGO*

SUMMARY

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SUMMARY

The future role that AID will play in Ghana's national family planning program is uncertain. The current bilateral agreement between USAID/Ghana and the Government of Ghana (GOG) terminated at the end of March 1982. If a new agreement is signed, USAID is now willing to only provide centrally-funded contraceptives directly to the various family planning programs in the country, effectively reducing the role of the Ghana National Family Planning Program Secretariat (GNFPPS), which has been charged with planning and coordinating all family planning activities in Ghana since 1971. There is evidence that the GNFPPS has been ineffective and involved in improprieties that may lead to an audit. The GOG, however, may be unwilling to eliminate the GNFPPS or change its role in a way that would be acceptable to the Mission. If that is the case, the Mission may not take steps to revitalize the Commercial Retail Sales program and may decide to terminate its support in population and family planning to Ghana altogether.

With this backdrop of uncertainty, I assisted the Mission in completing the FY 1984 Contraceptive Tables, and assisted the Ministry of Health in its preparations to play a larger role in the management of its own family planning program. The tables were approved by the Mission, and copies of the tables were sent to AID/S&T/POP/PSPD after I returned to Atlanta. It should be noted that some of the programs will require contraceptive supplies this year; the programs and their supply requirements are summarized on page 6.

Before I departed Ghana, I wrote a preliminary trip report in which I suggested different mechanisms the MOH might employ to manage its program. User reporting and contraceptive supply management were emphasized in this report, of which copies were given to the MOH. In addition, a copy of the

"Logistics Guidelines for Family Planning Programs" manual, developed by FPED/CDC, was also given to the MOH for its use in developing a contraceptive supply system. The Mission requested that FPED/CDC consultants return to Ghana in 6 months to evaluate the progress of the MOH program.

I. PLACES, DATES, AND PURPOSE OF TRAVEL

Ghana, March 8-24, 1982, at the request of USAID/Ghana and AID/S&T/POP/FPSP, to assist USAID/Ghana in preparing the FY 1984 Contraceptive Procurement Tables. In addition, technical assistance was provided to the Ghanaian Ministry of Health in its preparations to assume greater control over its clinic family planning program. This consultation was provided by Richard S. Monteith, M.P.H., Program Evaluation Branch, Family Planning Evaluation Division (FPED), CHPE. This travel was in accordance with the Resource Support Services Agreement (RSSA) between the Office of Population, AID, and FPED/CHPE/CDC.

II. PRINCIPAL CONTACTS

A. USAID/Ghana

- (1) Mr. Gerald Zar, Mission Director
- (2) Mr. Larry Sifers, Deputy Mission Director
- (3) Mr. Larry Eicher, Chief, Health, Population, and Nutrition Division (HPN)
- (4) Ms. Joanna Laryea, Population Coordinator, HPN
- (5) Mr. Michael Zak, Program Officer

B. Ghana National Family Planning Program Secretariat (GNFPPS)

- (1) Dr. A. Armar, Executive Director
- (2) Mr. S. K. Kwafu, Deputy Director
- (3) Mr. M. Acquaye, Senior Supply Officer
- (4) Mr. E. Osei-Kissih, Supply Officer
- (5) Mr. Thompson, Supply Officer

C. Ministry of Health (MOH)

- (1) Dr. Yaw Aboagye-Ata, Deputy Director, Medical Services (Public Health)
- (2) Mrs. Arde-Acquah, Deputy Director, Nursing Services (Public Health)
- (3) Ms. Victoria Asuan, Public Health Nurse, Maternal/Child Health and Family Planning Division
- (4) Mr. Hansen, Principal Supply Officer

D. Other

- (1) Mrs. Gladys Azu, Executive Secretary, Planned Parenthood Association of Ghana (PPAG)
- (2) Mr. D.A. Dartey, Executive Secretary, Christian Council of Ghana (CCG)
- (3) Mrs. Agnes Hughes, Assistant, Medical Section, CCG
- (4) Mr. Alfred A. Sarkodee, FLEC Project Coordinator, National Council of Ghana Young Men's Christian Associations (YMCA)
- (5) Dr. Ralph Summan, Consultant, Commercial Retail Sales Project
- (6) Mr. Barney Heidemann, Managing Director, DANAPCO, Ltd.

III. BACKGROUND

The current bilateral agreement between USAID/Ghana and the Ghana Ministry of Finance and Economic Planning (MFEP), to provide support in population and family planning, terminated at the end of March 1982. Under this agreement AID has supported, through the Ghana National Family Planning Program Secretariat (GNFPPS), an entity of the MFEP charged since 1971 with planning and coordinating all family planning activities in Ghana, several activities including training and research. In addition, AID provided contraceptives to the GNFPPS for the Ministry of Health (MOH) and Commercial Retail Sales (CRS) programs. If a new agreement is signed with the Government of Ghana, AID is now willing to provide only centrally-funded contraceptives directly to the programs. To some extent, a new agreement will be linked to the acceptance by the MFEP of a Memorandum of Cooperation, which spells out the terms governing cooperation between the MFEP and DANAFCO, Ltd., the former packer/distributor for the now defunct CRS program. Essentially, the Memorandum of Cooperation effectively excludes the GNFPPS from any management role in the CRS program and sets the conditions under which the program will operate. If the Memorandum of Cooperation is not acceptable to the MFEP, the Mission will not take any additional steps to revitalize the CRS program.

In other negotiations, the MFEP has agreed that the MOH rather than the GNFPPS should control the contraceptive supplies that are used in the MOH clinic program. Thus, the GNFPPS will be instructed to transfer existing inventories to the MOH. In addition, almost 700,000 cycles of oral contraceptives, which recently arrived at Tema port for the MOH program, will be consigned to the MOH rather than to the GNFPPS. The transfer will not directly affect the other family planning programs in the country that receive AID commodities, e.g., the PPAG, CCG and YMCA programs.

I agree with the Mission's decision to seek a reduction in the role of the GNFPPS. My previous TDY to Ghana revealed that it has not been effective in recent years in planning and coordinating family planning in Ghana; for example, it is unable to collect, process, and analyze data that are necessary for planning and coordination (see CDC Foreign Trip Report: Ghana, July 23, 1981). During this consultation I found evidence in GNFPPS supply records that suggests that some of the GNFPPS activities may go beyond the spirit and letter of the current program agreement, e.g., development of an unofficial commercial sales program in competition with the official CRS program. I also found that some GNFPPS personnel may be misusing contraceptive commodities for personal gain at the expense of rural MOH facilities, which have experienced chronic shortages of these commodities in recent years. The Mission is considering conducting an audit.

Perhaps one of the most important reasons to reduce the role of the GNFPPS is to inject new life into the MOH clinic program. The MOH program has languished in recent years under the control of the GNFPPS and because the program was controlled by the GNFPPS, the Ministry had very little incentive to improve it. Of course, the MOH is enthusiastic now over the fact that they will be controlling the contraceptive supplies used in their program and

exercising greater control in managing their program. I believe this change in control of the MOH program will translate into a greater commitment on the part of the MOH to the clinic program and, thus, an improvement in all parameters that are associated with a successful program.

What the future role of the GNFPPS will be is unknown. At the present, its role is reduced with the transfer of commodities to the MOH, and will be further reduced if it plays no role in the CRS program. However, the MFEP may be unwilling to eliminate the GNFPPS or change its role in a way that would be acceptable to AID. If that is the case, the Mission may decide to terminate its support in population and family planning to Ghana altogether.

With this backdrop of uncertainty about the future of family planning assistance to Ghana, I assisted the Mission in completing the FY 1984 Contraceptive Procurement Tables, and consulted with the Ministry of Health on their preparations to play a larger role in the management of its own family planning program. A preliminary trip report was left with the Mission prior to my departure.

IV. FY 1984 CONTRACEPTIVE PROCUREMENT TABLES

My previous report, dated July 23, 1981, described the user reporting and supply systems used in Ghana. In addition, levels of activity by program were also summarized.

In completing the FY 1984 Contraceptive Procurement Tables, I prepared separate sets of tables for each program that currently receives or will receive AID centrally-funded contraceptives rather than prepare one set of tables for the entire country. Thus, individual sets of tables by method, e.g., oral contraceptives and condoms, were prepared for the CRS, MOH, CCG, and YMCA programs, and for the Association of People for Practical Life Education (APPLE) program, which is tentatively scheduled to begin in June or July, 1982. Dr. Ralph Suman, a consultant to the CRS program, assisted in preparing the tables for the CRS program. Preparing separate tables by program and by method was suggested by Mr. Tony Boni, S&T/POP/FPSPD. One of the advantages of preparing separate tables is the assurance that future shipments of contraceptive supplies to Ghana will be consigned to individual programs rather than to just one, e.g., the CRS program, which was the case from 1978 to 1981.

Due to the absence of data on the commercial sector, I did not complete Table 1 of the Contraceptive Procurement Tables, which is a summary analysis of the availability and use of contraceptives in the country from 1981 through 1987. Data appearing in Table 1 is often very tentative and sometimes misleading and affects the calculations in Table 2. Table 2, Inventory Analysis of Orals and Condoms, is the critical table with respect to calculating AID's supply requirements. Thus, the estimates that appear in Table 2 more closely reflect present and future contraceptive requirements of the individual programs supplied by AID. Of course, the estimates should be modified as the accuracy and completeness of reporting improves and when the results of the World Fertility Study (WFS), conducted in Ghana in 1979, become available. Also, when WFS results on sources of contraception are available, it may be possible to make private sector estimates for Table 1.

Critical to estimating supply requirements are accurate data on current and past use of contraceptives, e.g., number of contraceptives dispensed to users, and supplies on hand in central and regional stores. The only data that the GNFPSS could provide me were balances on hand at central stores, and a physical inventory revealed that these data were not even up-to-date. In an attempt to obtain data on balances on hand in the nine MOH regional warehouses where the GNFPSS stores supplies in the field, I requested that the GNFPSS phone or cable GNFPSS regional coordinators to provide this information. None of the coordinators had responded by the time I departed Ghana.

Reporting of contraceptives dispensed to users still remains a problem 9 months after my previous consultation in Ghana last June. At that time I recommended that the computerized data system, used in the past by the GNFPSS, be eliminated and be replaced with a simple manual system modeled after the system used by the PPAG (see CDC Foreign Trip Report, Ghana, July 23, 1981). I still stand by that recommendation. Although a new form was designed and implemented by the GNFPSS to manually record quantities of contraceptives dispensed to users, reporting has continued to be incomplete and sporadic with only about 50 percent of clinics reporting data.

In the absence of complete data on contraceptives dispensed to users, I used quantities of contraceptives issued by the GNFPSS as a surrogate measure of contraceptive use in completing the tables for the MOH program. However, because the GNFPSS supply records were not up to date and in disarray, e.g., double counting and indiscriminate use of varying lot sizes to record supply transactions, it took GNFPSS staff several days to provide me with data on issues. Even then, they were calculated indirectly, i.e., starting balance plus receipts minus ending balance, rather than being the sum of individual issues over the course of 1981. There is nothing wrong with indirectly "calculating" issues as described above. However, the fact that the only way to determine issues was by indirectly calculating them indicates the poor quality of the GNFPSS records.

The following assumptions were made in completing the Contraceptive Procurement Tables.

- (1) The CRS program will be revitalized and operational by mid-year, and the Association of People for Practical Life Education (APPLE) program will be implemented in June or July 1982. If the CRS program is not revitalized and the APPLE program is not implemented, AID's supply requirements will, of course, need to be reduced. At the same time, estimates of contraceptive requirements for the MOH clinic program may need to be recalculated to compensate for the lack of a CRS activity.
- (2) Ninety percent of the oral contraceptives and condoms issued by the GNFPSS in 1981 were issued to the MOH; the MOH dispensed these contraceptives to users in the same year; and the MOH will dispense the same quantities to users in 1982. For 1983 through 1986, expected use of orals will increase by 10 percent annually and for condoms, 5 percent annually. I may have underestimated the potential of the MOH program to grow, but the lack of a communication infrastructure in the country, the limited resources of the MOH, and the presence of a CRS program will preclude, in my opinion, any rapid expansion of the program.

- (3) The MOH program will dispense only colored condoms (Tahiti) while the CRS program will market both the colored and plain condoms (Panther logo). Norminest, the low-dose oral contraceptive procured by AID, will not be introduced into the Ghana program at this time and when it is, it will be introduced initially through the CRS program, which is the best equipped of all programs in Ghana to sensitize the market to the new product and to the indications for its use. Given the MOH's inexperience in managing contraceptive supplies, I feel that the availability of two types of condoms and oral contraceptives would only add more difficulty to an already complicated situation.
- (4) The CCG, YMCA, and APPLE programs share of the contraceptive market will remain relatively small compared to that of the CRS and MOH programs and will experience slow but gradual growth from 1982 to 1986.

In the tables, I set "desired end-of-year stock requirements" at either 125 percent or 150 percent of expected use for the subsequent year. This was done to compensate for the preliminary nature of the data used in the tables to forecast future requirements, to reduce or eliminate borrowing among programs, to ensure that adequate supplies are always on hand given the distance the Ghanaian programs are from their off-shore supplier, and to establish a full-supply situation under which it would be possible to determine actual usage, assuming that completeness and quality of reporting improves.

It should be noted that some of the programs will require supplies this year in order to meet expected demand and to begin to fill the pipeline. These programs and their supply requirements are summarized in the following table.

Contraceptive Requirements for 1982
by Program and Method

<u>Program</u>	<u>Oral (Cycles)</u>	<u>Colored Condoms (Pieces)</u>	<u>Plain Condoms (Pieces)</u>
CRS	379,400	1,050,000	2,348,000
MOH	-	1,942,700	-
APPLE	13,000	30,000	-

Finally, the completed tables were reviewed and approved by Mr. Eicher and Mr. Safers. On March 31, 1982, after returning to Atlanta, I sent xerox copies of the tables to Ms. Mary Selinkar, AID/S&T/POP/FPSD who later in the week received a cable from USAID/Ghana officially approving the tables.

V. MINISTRY OF HEALTH

As mentioned above, the MOH will now be controlling the contraceptive supplies used in its clinic family planning program and exercising greater control in the management of its program. Ms. Victoria Annan, Public Health Nurse, Maternal and Child Health/Family Planning Division, will be responsible for

the day-to-day management of the MOH program. She will be assisted by Mrs. Arde-Aquah, Deputy Director, Nursing Services (Public Health) and a medical officer from the Greater Accra Health Region, who will be assigned part-time to the MCH/FP Division. Although Ms. Assan has clinical experience in family planning, this is her first opportunity to manage a national program.

When the GNFPPS was charged with the responsibility of coordinating the MOH program, MOH personnel played a minor role in the management of their own program. As a result, the MOH is presently faced with the task of developing the mechanisms and procedures that are needed to manage a clinic-based family planning program integrated with MCH care. Due to the continuing negotiations between AID and the MFEP and GNFPPS and the transition of responsibility to the MOH, it was impossible to discuss in any detail the different mechanisms the MOH may want to consider to employ to manage its program. However, in my preliminary report to USAID/Ghana, I wrote detailed sections on user-reporting and contraceptive supply management that may be appropriate for the MOH program. These sections of the preliminary report were to be xeroxed and given to the MOH. In addition, a xerox copy of the "Logistics Guidelines for Family Planning Programs" manual, developed by FPED/CDC, was also to be given to the MOH. Highlights of the preliminary report that are applicable to the MOH are summarized below. The entire preliminary report is available upon request.

Highlights of Preliminary Report

- (1) In order to simplify data collection and reporting, I recommended that only the number of contraceptives dispensed to users be collected and reported. An example of a form to collect and report data was included.
- (2) I recommended that active users be estimated from supply data by converting number of contraceptives dispensed to users to Couple Years of Protection (CYP). Conversion factors were suggested for each method used in the MOH program, and an example in calculating CYP was given.
- (3) Frequency and responsibility for reporting as well as reporting formats were also discussed.
- (4) I listed the outstanding issues that need to be addressed by the MOH and Mission in order to transfer existing contraceptive stocks from the GNFPPS and from the Port of Tema to the MOH medical stores in Tema.
- (5) A discussion of warehouse management of contraceptives, maximum and minimum stock levels, inventory management, delivery schedules, and reporting was also included in the preliminary report.

The mechanisms and procedures the MOH elects to use to manage its program should be simple and easy to implement. Hopefully, the material I left with the MOH will be useful in developing the needed management controls. Given the inexperience of Ms. Assan, I strongly urge the Mission to support her in

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every way possible. This can be done by periodic visits to the MOH to monitor the development of the clinic program and by requesting consultants from centrally-funded organizations, such as FPED/CDC, to provide technical assistance to the MOH in designing, implementing, and evaluating its program. The Mission requested that FPED/CDC consultants return to Ghana in September or October of this year.

A handwritten signature in black ink, appearing to read "RS Monteith". The signature is written in a cursive, somewhat stylized font.

Richard S. Monteith, M.P.H.