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Memorandum

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Subject Foreign Trip Report (AID/RSSA): Ghana, February 11-22, 1984--Followup Evaluation of Ghana Ministry of Health Contraceptive Supply and User Reporting Systems

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Director, Centers for Disease Control
Through: Dennis D. Tolsma
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SUMMARY

During this consultation we evaluated progress of the Ghana Ministry of Health (MOH) in implementing a contraceptive supply and user reporting system, and assisted USAID/Ghana in the preparation of the FY 1986 contraceptive procurement tables. This was the fourth consultation made by DRH/CDC consultants related to the MOH program systems.

Since the previous CDC visit in April 1983, notable progress has been made in the collection of MOH supply and user data required for monitoring the program. While the system is still less than fully functional, for the first time it was possible to set up the types of tables the management system is designed to produce. These tables yielded preliminary findings on levels and trends of new and active users, and number of months of contraceptive commodities and supplies on hand for most of the 10 regions of Ghana. Based on our analysis of these data, we recommend that USAID/Ghana cancel a shipment of 1.5 million condoms scheduled for June 1984. We further recommend that the budget allocation for the condoms be transferred to purchase urgently required contraceptive foaming tablets for the MOH.

After adjusting third quarter data for 1983 for nonreporting, we estimate that the MOH served 35,000 active users, or 1.7 percent of currently married women age 15-49, during that quarter.

Analysis of supply data showed that the MOH has been successful in moving contraceptive supplies to the periphery. In contrast, MOH clinics were undersupplied when the Ghana National Family Program (GNFPP) Secretariat was responsible for resupply. The analysis also demonstrated that the allocation system used to date by the MOH does not take into consideration usage rates and balances on hand as previously recommended by CDC consultants. As a result, condoms and IUD's are currently oversupplied at the clinic level. We recommend that the MOH transfer excess condoms to other service providers in the country. However, given the transportation difficulties in Ghana, it is not likely that the MOH will be completely successful in executing the transfer. We recommend that the Mission monitor the transfer, and that the condom procurement tables we prepared remain valid until the Mission indicates otherwise.

Although the MOH has made considerable progress in supply management and user reporting, problems still exist such as supply imbalances, lack of transport, and lack of reportng forms. Our recommendations to resolve these problems are presented in section IV-E.

I. PLACES, DATES, AND PURPOSE OF TRAVEL

Ghana, February 11-22, 1984, at the request of USAID/Ghana, to assist the Ghana Ministry of Health (MOH) in an evaluation of its contraceptive supply and user reporting systems, and to assist USAID/Ghana in completing the FY 1986 Contraceptive Procurement Tables. This travel was in accordance with the Resource Support Services Agreement (RSSA) between the Office of Population, AID, and DRH/CHPE/CDC, and was made in conjunction with a consultation in Nigeria during the period February 23-March 9, 1984.

During most of consultations in both Ghana and Nigeria, the CDC team was accompanied by Mr. Lawrence R. Eicher, Population Advisor, AID/AFR/TR.

II. PRINCIPAL CONTACTS

A. United States Embassy
   1. Mr. Robert Fritts, Ambassador

B. USAID/Ghana
   1. Mr. Leroy Wagner, Mission Director
   2. Mr. Tom Luche, General Development Officer
   3. Mr. John Thomas, Acting Agriculture Development Officer
   4. Ms. Joanna Laryea, Population Coordinator

C. Ministry of Health
   1. Mrs. Adelaide Arde-Acquah, Deputy Director, Nursing Services (Public Health)
   2. Ms. Victoria Assan, Family Planning Coordinator, Maternal-Child Health and Family Planning Division
   3. Dr. Joseph Otoo, Director of Training, Public Health

D. Other

1. Mr. D. A. Dartey, Executive Secretary, Christian Council of Ghana (CCG)
2. Mrs. Elizabeth Dogbey, Supply Officer, CCG
3. Mr. Alfred A. Sarkodee, National General Secretary, National Council of Ghana Young Men's Christian Associations (YMCA)
4. Dr. Robert (Bro) I. Russell, Director of Development, Association of People for Practical Life Education (APPLE)
5. Mrs. Fanny Dontoh-Russell, Executive Director, APPLE
6. Ms. Comfort Aboagye, Project Officer, APPLE
7. Mr. Michael Baddoo, Ministry of Finance and Economic Planning
8. Mr. Samuel Kwafo, Ghana National Family Planning Program Secretariat (GNFPP)

III. BACKGROUND

This was the fourth consultation made by CDC consultants related to the MOH contraceptive supply and user reporting systems. The last consultation was conducted during the period March 28-April 11, 1983, when it was found that implementation of the system was not complete. At that time, lack of transportation and printing materials were cited as major factors in slowing implementation. It was also found that reporting was not universal, and that the data that were reported varied in quality. That evaluation also revealed that stock issues were not based on recommended stock levels and quantities dispensed to users, which led to supply imbalances (over- or undersupply) in the field.

At the time of the last consultation, diplomatic relations between the United States and Ghana were strained. Also shortly afterwards, the USAID Health, Population, and Nutrition (HPN) officer, Mr. Lawrence R. Eicher, was transferred to Washington, D.C. Since that time, no new AID activities have been undertaken, and due to Mission staff reductions the HPN position was eliminated. Given these circumstances, the MOH continued to implement the contraceptive supply and user reporting systems with little, if any, Mission involvement. In addition, lack of transportation became even more severe due to lack of vehicles and petrol shortages. Lack of printing materials also continued as a problem.

The purpose of the present consultation was to evaluate progress since our last evaluation and to make recommendations for improvement. We were asked to complete the Contraceptive Procurement Tables for FY 1986, and to advise the Mission whether it should approve a shipment of 1.5 million condoms currently scheduled for shipment to Ghana in June 1984.

IV. FOLLOWUP EVALUATION OF CONTRACEPTIVE SUPPLY AND USER REPORTING SYSTEMS

A. General

Since the previous CDC visit, notable progress has been made in the collection of MOH supply and user data required for monitoring the program. While the system is still less than fully functional, for the first time it was possible both to set up the types of tables which the management system is designed to produce, and to actually produce some prototype tables which yield preliminary findings on levels and trends of new and active users, total client visits, and number of months supply of contraceptive commodities on hand for most of the 10 regions of Ghana.

The system and procedures previously established for collecting and submitting data required for program management is at least partially operational, though as discussed in the "problems" section, serious impediments remain which require remedial action.

Using the data that have been submitted from clinics to districts, districts to regions, and ultimately to the central MCH/FP office in Accra, we worked with the relevant MOH officials during this consultation in establishing procedures for summarizing information on the national program required for monitoring and future planning.

While recognizing the inadequacies of estimates based on incomplete data, we consider it appropriate to present five summary tables which are illustrative of the types of information which can readily be extracted from the data system, and which have direct management implications.

Our analysis covers the first three quarters of 1983. Data for the fourth quarter were incomplete at the time of our consultation.

B. User Reporting

Table 1 gives the number of new acceptors recorded in each of the first three quarters of 1983 for each reporting region. The national total of new acceptors must be considered to be an undercount, both because some regions failed to report and because some clinics within reporting regions also failed to report to the district supervisor. Consequently, the figures are likely to understate actual acceptance levels, and similarly to understate client visits and active users, as shown in Tables 2 and 3, respectively.

In all cases, these findings can be related to the "target population" of married women of reproductive age (MWRA), to yield proportions of women reached by the program at any given time.

Table 2 gives the total number of client visits by quarter. Comparing Tables 1 and 2, it may be noted that new acceptor visits account for roughly between 26 and 29 percent of all visits. The very high second quarter figure for Volta is considered questionable, since it does not correspond to either the first or third quarter figures. These data should be investigated and modified, if appropriate.

Table 3 presents the regional and national estimates of active users served by the MOH program. The third quarter figure of about 25,000 users suggests that actual use, after adjusting upward for nonreporting, is at least 31,000 and may be closer to 40,000. Based on an intermediate estimate of 35,000 users and a national female population aged 15-49 of 22.5 percent of Ghana's estimated 12 million population, and the further assumption that 73 percent of these 2.7 million women are in current stable sexual unions, Ghana has a target population of approximately 2 million women.* Thus, we can estimate that approximately 1.7 percent of currently eligible women are using MOH program methods. This figure is not comparable with the 1979-80 Ghana Fertility Survey (GFS) estimate of 7.2 percent using efficient methods, since this latter figure is based on "currently married, fecund women who were not pregnant."

The GFS figure, if readjusted to correspond with our less restrictive definitions of eligibility, would be reduced to approximately 5 percent. While this is still considerably above our estimate, it does not appear to be inconsistent with it, since we have not considered the combined contributions of such other organized service providers as the Planned Parenthood Association of Ghana (PPAG), the Christian Council of Ghana (CCG), and the YMCA, nor the contribution of the private sector. Thus, the MOH is making a contribution of approximately 35 percent to overall contraceptive practice in Ghana which, however, remains very low, as indicated by these findings. Much of this can be explained by the fact that there was little or no family planning activity in the MOH when its program was controlled by the GNFPP. The MOH assumed control of its family planning program mid-year 1983.

Based on our estimates, the levels of current use vary among regions from a high of about 3.0 percent in the Western Region (second quarter), to a low of only 0.3 percent in the predominantly Muslim Northern Region. The Upper West and Upper East regions did not report.

C. Supply Reporting

Table 4 shows months of supply on hand at the end of each quarter at combined clinic, district, and regional levels for all contraceptive methods in the MOH inventory. (Note: The injectable contraceptive, Depo-Provera, is donated to the MOH in small quantities by the PPAG). This analysis does not include supplies on hand for central stores, nonreporting regions, and nonreporting clinics within reporting regions. Thus, the data in this table may somewhat understate months of supply on hand, depending on usage rates and balances on hand in the nonreporting regions/clinics.

*A national population census was held on March 10, 1984. Eventual release of tabulations from this undertaking should prove helpful in future efforts at assessing program impacts.

As the table shows, months of supply on hand at the end of each quarter vary by method. Differences between quarters are explained by movement of supplies from central stores to the regions and by changes in usage rates of the different methods.

Focusing only on the third quarter, it is clear that an oversupply of condoms and IUD's existed in the field at the end of this most recently reporting quarter. This is explained by the lack of popularity of these two methods relative to other methods, availability of trained personnel in the field to prescribe and insert IUD's, and an MOH policy to dispense contraceptives with the earliest manufacture date first, without regard to the potential difference in acceptability to clients between colored and plain condoms.

Methods which are undersupplied in the field include injections and foaming tablets (NeoSampoon), neither of which are procured by AID, and vaginal cream. (Note: Maximum stock levels will be discussed later in this report.) A slight oversupply of Noriday oral contraceptives existed in the field at the end of the third quarter, but this is not problematic given its popularity.

Table 5 shows average months of supply on hand by type of stores. Thus, individual clinic, district, or regional stores may have more or less than the indicated average months of supply on hand. This table is useful in identifying bottlenecks in the flow of supplies, and whether the different storage levels are in compliance with program policy regarding maximum stock levels. As the table shows, from slightly less than half to two-thirds of the condoms stored in the field are found at the clinic level. A similar situation exists for IUD's. In contrast, MOH clinics were undersupplied when the GNFPP Secretariat was responsible for resupply. However, this demonstrates that the allocation ("push") system used to date by the MOH does not take into consideration usage rates and balances on hand as previously recommended by CDC consultants. Given the transportation problems of the country, it may be difficult to resolve this problem in the short run.

A further analysis of Table 5 shows that the MOH is not hoarding scarce supplies, i.e., injections, foaming tablets, and vaginal cream, at intermediary storage levels; existing stocks are at the clinic level where they should be. This analysis also shows that once the clinic supplies are dispensed, these methods will not be replaced at the clinic level until additional supplies are procured from off-shore sources.

Tables not included in this report were prepared and submitted to the MOH to show the supply status of each type of store in the regions by method. These tables are intended to be used in identifying supply imbalances in the regions and in making decisions regarding the transshipment of commodities from region to region and within regions.

Finally, Table 6 shows supplies on hand in Central Stores at the end of each quarter of 1983 and as of February 20, 1984. This table demonstrates that the MOH has been successful in moving supplies to the periphery despite its transportation problems. In the case of condoms and IUD's, the MOH has actually been too successful (See Table 5).

The table also shows months of supply on hand as of February 20, 1984. This analysis shows that colored condoms and IUD's are oversupplied while Noriday is close to being in compliance with program policy of a 12-month maximum supply at Central Stores. However, it should be noted that this analysis somewhat overstates months of supply on hand, since nonreporting regions/clinics are not included in the analysis, nor is an expected increase in use of contraceptive methods provided through the MOH program taken into consideration. Stockouts (zero balances) are evident for foaming tablets, foam, and injectables.

We realize that the supply imbalance picture could change substantially if there is a dramatic increase in demand for contraceptives. One cannot predict which methods would be favored or the magnitude of any change. We therefore recommend that program managers watch these trends very closely (which can only be done if there is an accurate and complete reporting system) so that adjustments can be made as needed.

The purpose of this exercise was primarily to indicate the types of program relevant data which can readily be derived from the present supply and user reporting systems once some of the reporting problems have been ironed out. Such data, which can be produced also for subregional (district and clinic) levels, can be used to track progress in family planning activities and to monitor the adequacy of supplies and the need for additional programmatic activity.

D. Problems Identified

Although the MOH has made considerable progress in supply management and user reporting, problems still exist. Some of these were identified during our previous consultation.

1. Supply Imbalances. To date, stock issues have not been based on recommended stock levels and quantities dispensed to users. This indicates that the supply and user reporting system is not used in determining issue quantities at all levels of the system.

   Currently, previously suggested guidelines for maximum stock levels at the local (clinic), district, or regional levels are not used. This, along with a lack until now of basic data required to compute months of stock on hand at any given level, has contributed sometimes to severe overstocking.

   Lack of supplies has also created supply imbalances. This is true for foaming tablets, which had attained a significant level of popularity but are currently unavailable; and the injectable, Depo-Provera, which is not procured by AID and is not currently available to the MOH in adequate quantities from other sources. Vaginal cream is another method which is currently in short supply in most regions.

2. Lack of Transport. A chronic problem at all levels of the program is the lack of adequate transport. This impedes attempts to resupply on a timely basis, to provide for adequate supervision and in-service training, and to collect monthly activity forms. Since functioning MOH transport is virtually nonexistent, staff must resort to use of infrequent and very unreliable public transport, with the consequence that much time which could otherwise be devoted to professional efforts is wasted. Furthermore, reimbursement for such travel, when available at all, is inadequate, with predictable consequences for staff morale.

3. Lack of Forms. No effective system for monitoring the supply status of the program can exist if requisite forms are not available. A lack of paper, stencils and ink, identified during our previous consultation, remain as chronic problems. Forms provided by USAID in April 1983 were exhausted in 6 months, and no alternative mechanism to obtain the necessary printing supplies were established in the interim. We were informed by MOH personnel in one region we visited that this was the reason that no reports have yet been submitted for the third and fourth quarters of 1983.

4. Miscellaneous. Several other smaller problems were encountered. They include:

   (a) Lack of staff at central level to assist in processing and analyzing incoming data and to supervise the supply and user reporting systems. In our previous report, we recommended assigning up to two statistical clerks to the MCH/FP division.

   (b) Contraceptive commodities are still stored in Bay 3 at the MOH Central Medical Stores in Tema. This is contrary to our previous recommendations, since Bay 3 has the potential of water damage. During our visit to Tema, we also discovered commodity loss due to pilferage and rodent damage to shipping cartons. We also found that first-in, first-out (FIFO) had not been observed in some cases due to the storage of commodities in two separate locations.

   (c) We noted in some instances that MOH family planning staff were unaware that the current shipping cartons of Noriday contain twice the quantity of cycles as the previous cartons (1,200 versus 600). Failure to note this change could result in serious misreporting of balances on hand.

   (d) We observed that most reporting forms contained some blank cells. While one is tempted to assume that blanks signify zeros, this may not always be the case; they may represent missing or unavailable data. We also noted arithmetic errors on some forms.

   (e) The two types of condoms, plain and colored, in the MOH inventory, have been considered equivalent with regard to FIFO. Consequently, the oldest stock on hand is issued, which results in one type of condom being issued to the exclusion of the other even if the former is in short supply, and denies clients their choice of brands.

(f) In some instances the Quarterly Report forms we reviewed did not clearly indicate the origin of the report and/or the reporting period.

E. Recommendations

1. Supply Imbalances

(a) Issues should be based on quantities dispensed to users and balances on hand. This is to be done at all levels. Formulas for determining issue quantities are:

District Stores to Clinics
Average quantity dispensed to users by the clinic during last 3 months TIMES maximum supply level assigned to t clinic MINUS balance on hand in clinic.

Regional Stores to District Stores
Aggregate average quantity dispensed to users by district clinics during last 3 months TIMES maximum supply level assigned to district stores MINUS balance on hand in district stores.

Central Stores to Regional Stores
Aggregate average quantity dispensed to users by regional clinics during last 3 months TIMES maximum supply level assigned to regional stores MINUS balance on hand in regional stores.

Taking into account transportation difficulties in the country, we recommend that maximum supply levels be:

Clinics--5 Months
District Stores--5 Months
Regional Stores--9 Months

Clinics and district stores should be resupplied quarterly. Thus, a 2-month safety stock will be available to both in the event resupply is postponed, or to handle unanticipated high demand. Regional stores should be resupplied every 6 months. Their safety stock would be equivalent to a 3-months' supply.

Maximum supply levels may be adjusted downward to 4, 4, and 7 months, respectively, once transport problems are resolved, reporting is improved, and off-take is stabilized.

Current supply imbalances should be rectified by using the above formulas. We recognize that transshipping will be difficult given the severe inadequacy of transportation, but we encourage the MOH to do the best they can.

The methodology cited in this recommendation has been explained and accepted by the MOH MCH/FP Division.

(b) AID should support an MOH request to other donors, such as UNFPA and IPPF, for assistance in providing the injectable contraceptive, Depo-Provera, to the MOH.

(c) AID should provide adequate quantities of centrally-funded foaming tablets and vaginal foam and creams to the MOH.

NOTE: Recommended quantities for these methods by calendar year are presented in the Contraceptive Procurement Tables.

2. Lack of Transport

AID should explore the possibility of procuring directly or through an AID-funded international donor such as UNFPA, five vehicles for exclusive use by the MOH MCH/FP program, and at least a 3-year supply of appropriate spare parts.

These vehicles will be used by MCH/FP zone coordinators to resupply regional and district stores and clinics, and for supervision and data collection. The zone coordinators will supervise from two to three regions. The vehicle assigned to the Central MCH/FP staff in Accra will be used for supervisory visits by the Central staff and for resupply in the Greater Accra Region. The vehicles and zone coordinators will be assigned to the following regions (See Figure 1):

(a) Central Office and Greater Accra
(b) Eastern, Volta
(c) Central, Western
(d) Ashanti, Brong Ahafo
(e) Northern, Upper East, Upper West

General specifications for the vehicles include:

(a) Heavy duty pickup, extra length cargo bed
(b) Diesel engine
(c) High clearance
(d) Seating for four (King Cab)
(e) Secured cover for cargo bed
(f) Heavy duty tires
(g) Local maintenance and repair potential

If these vehicles are provided, the following advantages should accrue:

(a) Improved timeliness of resupply
(b) Reduction of maximum stock requirements in the field, thus greater central control over the commodities
(c) Elimination of supply imbalances
(d) Improved timeliness of reporting
(e) Increased supervision/in-service training

3. Lack of Forms

In the short run, USAID/Ghana should donate a sufficient quantity of 8-1/2 x 14 paper to the MOH for the printing of a 6-month supply of Daily Log and Quarterly Report forms. This is equivalent to 40 reams (500 sheets each) of paper.

USIS/PAO (Ghana) is willing to print the forms if USAID donates the paper. Plates used last April (1983) to print the forms are available in the USAID office.

The long term goal should be for the MOH to utilize local currency generated from the sale of contraceptives to purchase paper and other necessary printing supplies.

Unfortunately, at present paper is not available on the local market. Therefore, as an interim solution, AID should explore the possibility of obtaining adequate quantities of printed forms through the centrally-funded Johns Hopkins/PCS project.

It should be kept in mind that the forms mentioned above are crucial for maintaining a viable management information system in Ghana.

4. Miscellaneous

(a) The MOH should assign two statistical clerks/supervisors to the MCH/FP central office. This recommendation was made in our previous trip report.

Presently, Mrs. Arde-Acquah and Miss Assan are the only two people in the MOH's central office assigned to manage the family planning program. Staff support is needed to process and analyze quarterly returns and to assist in field supervision. With the addition of two clerks/supervisors, Mrs. Arde-Acquah and Ms. Assan could devote more time to managing the program than acting as clerks, which is not their intended role.

(b) All contraceptive supplies stored at the MOH Central Medical Stores in Tema should be stored in one location, specifically in a bay that will not subject commodities to water damage. Improved security measures should also be implemented to prevent loss due to theft. In addition, pest control measures should be taken to prevent loss due to rodents.

(c) All levels of the family planning program should be informed that the current shipping cartons of Noriday oral contraceptives contain twice the number of cycles as the previous cartons. Storekeepers and clinic nurses should be advised to establish separate tally cards if both types of shipping cartons are in their inventory. Balances on hand should continue to be reported in terms of cycles.

(d) Cells in Monthly/Quarterly report forms should not be left blank. Zeros should be entered in the cells, as appropriate. In addition, all levels should be required to report the number of family planning clinics that are active in their jurisdiction and the number submitting reports during a given reporting period.

Errors in arithmetic can be reduced by checking one's work and by supervisors checking the work of their subordinates. Since the calculations needed to prepare quarterly reports at the district, regional, and central levels are laborious and require accuracy, we recommend that AID, either directly or through an intermediary, procure simple, inexpensive, solar-powered calculators for the supervisors at these levels. Approximately 75 calculators will be required.

(e) Colored and plain condoms should be treated as two different contraceptives. Both should be dispensed to users on the basis of the supply management principle of FIFO for each type of condom.

(f) All personnel preparing reports should be instructed to clearly annotate the origin of the report and the reporting period the report covers.

F. Estimating Active Users

Since this was the first opportunity for us in Ghana to estimate active users using data on contraceptive methods dispensed to users, we reviewed the methodology with our MOH counterparts. The methodology is based on Couple Years of Protection as developed by Dr. Sam Wishik.

The following annual and quarterly usage rates, which are referred to as "Conversion Factors," will be used to estimate active users served by the MOH program:

Method	Conversion Factors	
	Annually	Quarterly
Orals (cycles)	13	3.25
Condoms (pieces)	144	36
Foaming tablets (tablets)	144	36
Cream, Jelly, Foam (tubes)	6	1.5
Injections (Doses)	4	1

For methods such as IUD's and diaphragms, we look at usage in terms of the estimated average amount of time a woman will use these methods. This is approximately 2.5 years for IUD's and 1 year for diaphragms.

In order to estimate number of active users by method served by the program during the quarter (except IUD's and diaphragms), one simply divides the quantity of a specific method dispensed during the quarter by its corresponding conversion factor. For IUD's, we multiply by 10 (2.5 years = 10 quarters) and for diaphragms we multiply by 4 (1 year = 4 quarters).

Example:

	Quantity Dispensed During Quarter	Conversion Factor	Estimated Active Users
Orals	13,069	3.25	4,021
Injections	814	1	814
Condoms	9,789	36	272
Foaming tablets	21,040	36	584
Cream, Jelly, Foam	543	1.5	362
IUD's	266	10	2,660
Diaphragms	20	4	80
		Total	8,793

Thus, this example shows that an estimated 8,793 active users were served during the quarter. Stated more precisely, 8,793 quarters of contraceptive use were dispensed to users through program activities undertaken during the quarter.

This type of analysis can be done by clinic, by region, or for the entire program.

The proportion of married women 15-44 years of age served by the program can be determined from this analysis. Let us assume that census projections estimate that 458,000 married women 15-44 live in Region I. In order to determine the proportion of this population that is served by the program, the following calculation is performed:

$$\frac{8,793}{458,000} \times 100 = 1.9 \text{ percent}$$

G. Other Issues

It was brought to our attention during this consultation that the GNFPP Secretariat had expressed concern over the forms developed by CDC for use in the MOH. The GNFPP is a policy/coordinating unit of the Ministry of Finance and Economic Planning (MFEP) and would prefer continued use of Forms A and B, which were replaced at the MOH by the CDC recommended system. The CDC/MOH system was put into place because the GNFPP system has not been operational since 1978, and because the MOH needed a simple management tool to monitor its program. In addition, AID/W needed information to monitor the program and to forecast and procure contraceptive supplies for the program.

On February 20, 1984, the MFEP brought together representatives of the GNFPP, MOH, AID, and CDC in an attempt to resolve this issue. The meeting was chaired by a representative of the MFEP.

It was explained at the meeting that the MFEP has given the GNFPP national responsibility for family planning policy and coordination with other entities involved in family planning in Ghana. This is totally separate, however, from the day-to-day program and operational management of individual programs. These remain the sole prerogative of each entity (e.g., MOH, PPAG, Christian Council, etc.).

In the past, GNFPP relied on Forms A and B to develop data for reports to intermediaries and to the Government of Ghana (GOG). No reports, however, have been issued by GNFPP since 1978.

At this meeting, it was agreed that the MOH has no obligation to continue using the antiquated forms A and B. The MOH preference for the CDC forms is based on improving the management of their own program. MOH, however, agreed to provide to GNFPP on a quarterly basis aggregate data collected on the CDC forms, which GNFPP can then use in order to fulfill part of its national responsibility to the GOG. It was also agreed that if any additional data are needed, the GNFPP should consider collecting such data through special ad hoc surveys and not expect the MOH, PPAG, CCG, or YMCA to do this work for them.

The MOH may elect to use the back side of Form A to record clinical information on patients until a new form can be printed. We concur, and recommend that USAID, through an appropriate intermediary, assist the MOH in procuring this clinic form.

GNFPP plans to call a meeting of all family planning organizations in Ghana to further discuss the future of forms A and B, and compare these forms to the CDC management forms in use now by the MOH. So long as GNFPP can be assured that it can get data to fulfill its policy role using quarterly reports from these agencies plus special surveys, general agreement should easily be reached. MFEP will attend this meeting to ensure that agreement is developed freely while keeping in mind the operational management responsibilities of participating entities.

During the February 20 meeting, the issue of what to do about the proceeds from the sale of previously donated AID contraceptives still in the GNFPP accounts 2 and 3 were also discussed. These funds cover GNFPP program activities up to the transfer of program activities to the MOH in 1983. GNFPP agreed to call a meeting of all family planning organizations to develop a list of potential family planning activities for which the local funds could be utilized, subject to USAID's approval.

During this consultation, the CDC team received confirmation that the MOH has indeed established a special account for the proceeds derived from the sale of AID-donated contraceptives. Such an account is required now that the MFEP has given operational and management authority of the public clinic program to the MOH. We recommend that during the next few months the MOH prepare and present to USAID a plan, listing a number of worthwhile family planning activities which could utilize the local funds (cedis) derived from the sale of AID donated commodities.

V. CONTRACEPTIVE PROCUREMENT TABLES

During this consultation, we completed the FY 1986 Contraceptive Procurement Tables as part of the Annual Budget Submission for the following organizations: MOH, CCG, YMCA, and APPLE. With the exception of the MOH, these organizations receive their supplies from Family Planning International Assistance (FPIA), and the MOH receives its supplies from AID under a bilateral agreement.

The tables were submitted to USAID/Ghana before our departure. If the Mission approves the tables, it should cable S&T/POP/FPSD indicating this approval. We mailed copies of the tables to S&T/POP/FPSD after our return from Nigeria.

After completing the tables for the MOH, we recommended to the Mission that a shipment of 1.5 million condoms scheduled for June 1984 be cancelled. Since use of condoms has been less than anticipated, receipt of this shipment would exacerbate the existing oversupply situation. We therefore recommend that the budget allocation for the 1.5 million condoms be transferred to purchase other contraceptive supplies, i.e., foaming tablets.

In order to reduce the oversupply of condoms in the MOH and to provide the other family planning organizations in Ghana with needed supplies, we recommended that the MOH transfer condoms to the YMCA and CCG according to the following schedule:

Recipient	Quantity	Schedule
YMCA	895,000	Immediately
CCG	504,000	December 1984
CCG	771,000	June 1985
YMCA	426,000	June 1985
Total	2,596,000	

If the MOH is successful in transferring condoms to the YMCA and CCG, the condom procurement tables prepared during this consultation for these organizations would no longer apply, and would therefore require modification. However, given the fact that most of the condoms in the MOH inventory are located at the periphery and that the lack of transportation continues to be a chronic problem, it is our professional judgment that the MOH will experience difficulty in achieving the transfer. We therefore recommend that the Mission closely monitor the transfer, and that the condom procurement tables we prepared be considered valid until the Mission, after monitoring progress in the transfer, indicates otherwise.

In general, the preparation of the tables involved making assumptions about usage rates and program growth. Representatives of the CCG and YMCA programs reported increased demand for contraception among the populations their programs serve due to Ghana's economic situation. They were also concerned about stockouts (zero balances), which the CCG and YMCA had at the time of our consultation. For these programs, quantities over and above estimated demand were requested to fill the pipeline in order to eliminate borrowing between programs and to give each program the opportunity to operate under conditions of full supply.

Estimating contraceptive supply requirements for the CCG and YMCA, as well as for APPLE, once its family planning program gets under way, would be facilitated if their respective contraceptive outlets, i.e., clinics and distributors, were required to report quantities by method dispensed to users and balances on hand. This could be done by adopting the MOH system designed by CDC, or by modifying existing reporting systems. The GNFPP Secretariat representative at the February 20 meeting expressed interest in establishing a uniform reporting system among service providers in Ghana. This will be the topic of discussion in a future meeting of providers. We encourage their efforts toward reaching a consensus on collecting and reporting the data required for forecasting contraceptive requirements.

RS Monteith

Richard S. Monteith, M.P.H

J. Timothy Johnson

J. Timothy Johnson, Dr. P.H.

TABLE 1

Number of New Acceptors, by Region and Quarter
Ghana Ministry of Health
First Three Quarters, 1983

Region	Quarter		
	First	Second	Third
Total	5,464	6,207	5,962
Greater Accra	957	940	541
Volta	186	1,024	1,015
Brong Ahafo	583	897	844
Northern	152	171	320
Central	464	631	NA[1]
Eastern	840	727	1,057
Ashanti	782	917	2,185
Western	1,500	900	NA[1]
Upper East	NA[1]	NA[1]	NA[1]
Upper West	NA[1]	NA[1]	NA[1]

[1]Indicates that reports for these regions were not available.

TABLE 2

Total Client Visits[1], by Region and Quarter
Ghana Ministry of Health
First Three Quarters, 1983

Region	Quarter First	Second	Third
Total	20,482	32,398	20,789
Greater Accra	3,370	3,591	3,137
Volta	743	11,631[3]	2,319
Brong Ahafo	1,726	2,312	2,427
Northern	441	421	863
Central	1,404	1,897	NA[2]
Eastern	2,878	2,911	3,620
Ashanti	5,480	5,110	8,423
Western	4,440	4,525	NA[2]
Upper East	NA[2]	NA[2]	NA[2]
Upper West	NA[2]	NA[2]	NA[2]

[1]Includes visits made by new acceptors and continuing users to reporting clinics during reporting period.
[2]Indicates that reports for these regions were not available.
[3]The very high second quarter figure for Volta is somewhat questionable, since it is so much higher than the corresponding first and third quarter figures.

TABLE 3

Estimated Active Users, All Methods,
Ghana Ministry of Health
First Three Quarters, 1983

Region	Quarter First	Second	Third
Total*	21,278	37,156	24,623
Greater Accra	4,878	4,923	4,278
Volta	1,186	10,712[1]	4,069
Brong Ahafo	1,840	2,132	2,684
Northern	386	359	817
Central	1,368	2,512	NA[2]
Eastern	2,563	3,346	3,077
Ashanti	5,687	6,426	9,698
Western	3,363	6,746	NA[2]
Upper East	NA[2]	NA[2]	NA[2]
Upper West	NA[2]	NA[2]	NA[2]

[1]Please see Note 3, Table 2
[2]Indicates that reports for these regions were not available.

*NOTE: Regional totals are based only on reporting clinics. The national total is based only on reporting regions. This results in substantial understatement of the third quarter figures.

TABLE 4

Months of Supplies on Hand at Combined Clinic, District, and Regional Levels, by Method and Quarter
Ghana Ministry of Health
First Three Quarters, 1983

Method	Quarter		
	First[1]	Second[1]	Third[2]
Noriday	40.0	21.3	22.0
Condoms, Colored	40.8	76.7	61.6
Condoms, Plain	99.6	97.1	120.3
Foaming Tablets	11.0	6.7	9.9
Cream	16.3	9.2	10.7
Lippes "D"	92.1	109.0	178.0
Lippes "C"	505.9	287.0	349.1
Injection	2.1	1.2	6.0

NOTE: These figures are based on usage rates during the indicated quarter, and exclude commodities at the central warehouse.

[1]Excludes Upper East and Upper West regions.
[2]Excludes Central, Western, Upper East, and Upper West regions.

TABLE 5

Average Months of Supply on Hand by Type of Stores[1]
Ghana Ministry of Health
Third Quarter, 1983

Types of Stores	Condoms			Foaming Tablets	Cream	Lippes D	Lippes C	Injection
	Noriday	Colored	Plain					
Clinic	6.1	40.5	56.9	6.2	5.6	159.7	287.3	6.0
District	4.0	9.3	21.2	3.3	5.1	5.5	24.3	0.0
Regional	11.9	11.9	42.2	0.5	0.0	12.8	37.5	0.0
Subtotal	22.0	61.7	120.3	10.0	10.7	178.0	349.1	6.0
Central	42.8	271.1	2.9	0.0	0.0	78.8	1,045.5	0.0
Grand Total	64.8	332.8	123.2	10.0	10.7	256.8	1,394.6	6.0

[1]Aggregate data are used in this analysis.

NOTE: Due to rounding, the totals in this table do not always correspond to the third quarter totals presented in Table 4.

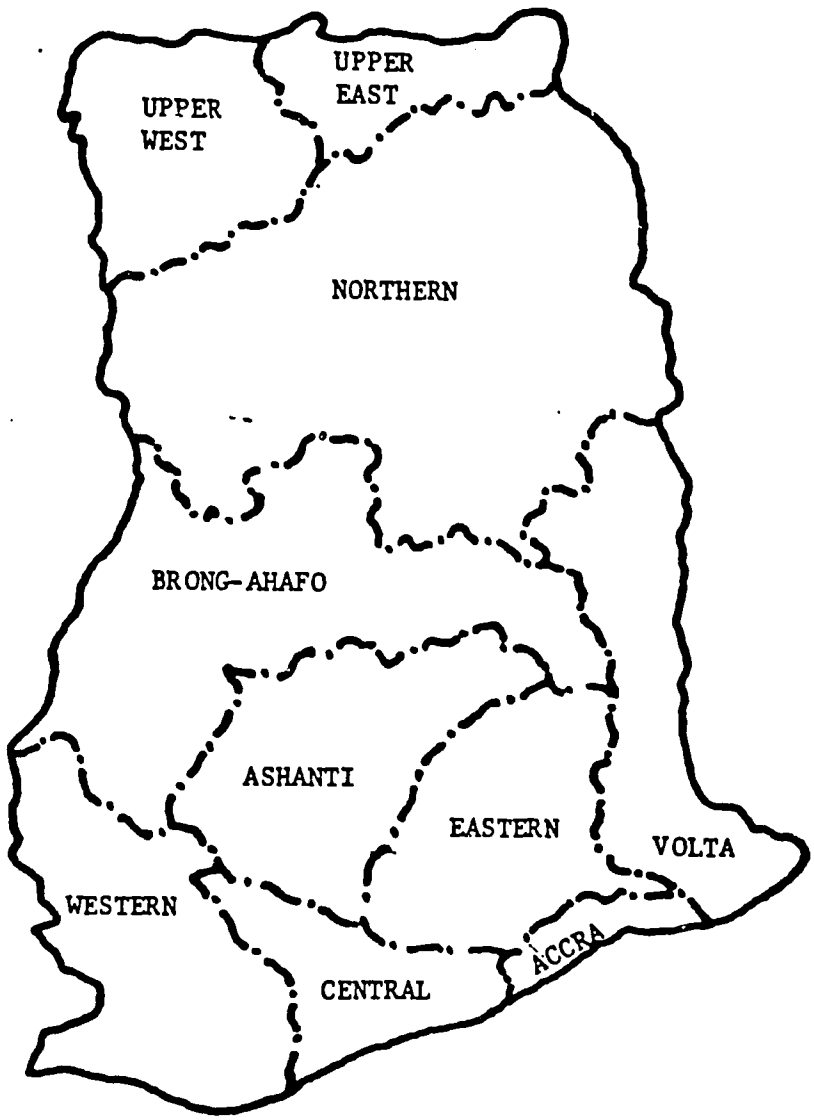
TABLE 6

Balance on Hand[1] by Selected Time Periods and Method
Ghana Ministry of Health Central Stores

Selected Time Periods	Noriday	Condoms		Foaming Tablets	Foam	Lippes D	Lippes C	Injectables
		Colored	Plain					
March 31, 1983	430,800	0	240,000	0	0	5,200	23,000	0
June 30, 1983	1,395,000	2,694,000	24,000	0	0	5,200	23,000	0
Sept. 30, 1983	1,395,000	2,694,000	24,000	0	0	5,200	23,000	0
Dec. 31, 1983	705,000	1,812,000	24,000	0	0	4,700	22,700	0
Feb. 20, 1984	367,200	270,000	24,000	0	0	4,400	22,400	0
(Months of Supply on Hand[2] as of Feb. 20, 1984)	(15.7)	(38.0)	(4.1)	(0)	(0)	(93.6)	(1,400.0)	(0)

[1]Quantities are expressed in the following units: Noriday--cycles; condoms--pieces; foaming tablets--tablets; foam--tubes; IUD's--pieces; and injectables--doses.

[2]Months of supply on hand were calculated using monthly averages of each method that were dispensed to users during the third quarter of 1983. Since nonreporting regions/clinics are not included in this analysis nor expected increase in use considered, these figures overstate months of supply on hand.

FIGURE 1

Ghana by Administrative Region