



## Memorandum

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Subject Foreign Trip Report (AID/RSSA): Gambia, March 16-21, 1987

To James O. Mason, M.D., Dr.P.H.  
Director, CDC  
Through: Assistant Director for Science, CHPE

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## SUMMARY

CDC consultant J. Timothy Johnson visited The Gambia during March 16-21, 1987, in response to a request for assistance to the Gambian Family Planning Association (GFPA) and to the population intern, on various projects that the GFPA is either engaged in or considering. In addition, a preliminary review of program commodity status was undertaken.

During this assignment, I worked closely with the University of Michigan's AID-supported population intern, Tamara Smith, who demonstrated a solid understanding of the strengths and weaknesses of organized family planning efforts, particularly of the GFPA to which she is attached.

Plans for the conduct of proposed studies on family planning client characteristics and on demand-creating motivational efforts, to be conducted by the GFPA, were discussed with Ms. Smith. We also looked at possible modifications of the present MIS (Section IV-A).

Our re-analysis of performance figures suggests that the GFPA may have somewhat overestimated contraceptive prevalence attributable to its activities, and that costs per client visit and per CYP are very high by international standards, suggesting that redeployment of resources to increase utilization of currently underutilized staff and clinics may be warranted (Section IV-B).

GFPA contraceptive inventories are adequate at present, except for the oral pill, of which only 4 months' supply was on hand at current use rates. However, this is not an emergency, since procedures to avoid stockouts through currently available in-country MOH and UNFPA stocks do exist (Section IV-C).

It was regrettably not possible to obtain from the MOH much of the information required to assess their contribution to national family planning efforts, since the key "gatekeeper" did not choose to facilitate my efforts. However, it was found that some sound Africare-initiated recommendations for contraceptive management are being implemented. In addition, MOH contraceptive stock inventories appeared to be adequate at least for this year and for most methods for well beyond 1987 (Section IV-D).

The possibility of a return CDC visit, particularly to undertake a more complete assessment of total program performance relative to need for family planning services, was raised, and tentative dates and procedures for requesting such assistance were also discussed (Section V).

#### I. PLACES, DATES, AND PURPOSES OF TRAVEL

CDC consultant Dr. Timothy Johnson visited The Gambia, March 16 to March 21, 1987, in response to an AID/Banjul request (cable 00417) for him to work with The Gambian Family Planning Association (GFPA), and especially with University of Michigan Population Intern, Ms. Tamara Smith, to discuss several research projects the GFPA is developing, and certain aspects of the GFPA recordkeeping and Management Information Systems (MIS). AID/W also requested that I check on contraceptive supply status, especially vis-a-vis AID/FPIA-supplied commodities. This assignment was in accordance with the CDC-AID/RSSA and was undertaken en route to a longer assignment in Nigeria, which is reported separately.

#### II PRINCIPAL CONTACTS

##### A. USAID, Banjul

1. Mr. Thomas Mahoney, Acting AID Director
2. Ms. Ida Ceesay, Population, Health, and Nutrition Officer

##### B. The Gambian Family Planning Association (GFPA)

1. Mr. J. Tunde Taylor-Thomas, Executive Director
2. Dr. Burang Goree-Ndiaye, Program Director
3. Mrs. Bintou Suso, Sr. Nursing Sister; Service Delivery Officer.
4. Mr. Momodou N'jie, Stores Clerk

C. Others

1. Ms. Tamara M. Smith, U. Michigan Population Intern with GFPA
2. Mr. James Y. Binka, Chief Pharmacist, Ministry of Health
3. Mrs. Grace Camara, UNFPA Population Officer

III BACKGROUND

The Gambia is one of West Africa's poorest and smallest nations, with a population of about 700,000. Based on most social indicators, it ranks among the most disadvantaged countries with infant mortality rates, for example, estimated to be above 170 per 1,000 births, and with a crude birth rate of 49, a TFR of 6.5, and an expectation of life at birth of less than 40 years.

While organized family planning services have existed since the 1969 advent of the GFPA, modern contraceptive practice remains very low.

CDC's past involvement in Gambian family planning has consisted primarily of two visits in 1983, first to advise on conduct of a retrospective study of the characteristics of clients of the GFPA (see Gambia trip report by Spitz, June 20, 1983) and a study of patient flow and staff utilization at six clinics of the GFPA and MOH (see Gambia report by Graves, November 23, 1983).

The present visit was prompted by a request to AID/W by AID/Banjul and the University of Michigan for consultation to the GFPA and particularly to the Universities Overseas Population Intern (Fellow), Tamara Smith, who is assisting the GFPA in program monitoring and evaluation, in the design of various proposed studies, and in assessing the status and progress of the GFPA program. In addition, to take advantage of this brief visit, AID/W asked me, to the extent possible, to look into program commodity status and to seek verification of AID records of past FPIA shipments of condoms, pills, and IUCDs to The Gambia.

IV. FINDINGS

A. Role of Intern

The University of Michigan Population Intern, Tamara Smith, has been working with the GFPA since August 1986. My impression is that she has developed a sound grasp of the strengths and weaknesses of present GFPA operations and of the activities required to define its information needs, and has developed an effective role for herself vis-a-vis overall GFPA development.

She has been instrumental in helping the GFPA to define areas of both routine recordkeeping and specialized studies in which there is currently a lack of adequate information for program guidance. However, she also recognizes that her own experience in planning and conducting evaluative studies and in developing routine recordkeeping and management information systems in family planning is somewhat limited, and was glad of the discussions we were able to hold on aspects of these activities.

We were able particularly to discuss the GFPA's plans for two proposed studies. The first of these involved a followup study of clinic acceptors to look into their characteristics and into correlates of clinic discontinuation. The second involves the role of motivational efforts in recruiting family planning

acceptors. In both cases, we discussed issues of study design, including optimal sample design, and costs and timetables for the studies.

We were also able to discuss the existing MIS system, which is currently undergoing some modifications. This was discussed in terms of the needs for information by and for the entire program, including both the MOH/MCH program in family planning and the GFPA's program. Some of these discussions were held after the analysis of GFPA contraceptive coverage (next section), which suggested that overall costs of the GFPA program, in terms particularly of costs per user, are very high, and that this results from some very costly subprojects. This in turn suggests that the GFPA, in order to be more cost-effective, needs to analyze its subprojects in order to determine how it can optimize its family planning interventions. Some crude preliminary approaches to estimation of subproject costs were discussed.

#### B. Contraceptive Coverage

Ms. Smith and I examined available data on commodities dispensed to users and concluded that probably between 3,300 and 3,400 CYPs could be attributed directly to GFPA activities in 1986, with at most an additional 1,250 CYPs being attributable to other GFPA-supplied providers. This suggests that GFPA prevalence among the estimated 140,000 eligible women would be about 2.4 percent, with considerably less than 1 percent additional prevalence through other GFPA supplied providers.

The GFPA claims that it currently accounts for 3-4 percent prevalence of modern contraceptive use in the country. Our examination of client records suggests that client continuation rates tend to be rather lower than the GFPA has assumed in making its coverage estimates. However, the differences are not too substantial. More significant is the finding, regardless of whose estimate of current use is employed, that the average cost per new acceptor and per current user, and by extension also per birth prevented, is very high by international standards. Dividing the total 1986 operating budget of the GFPA by various output indicators gives a cost of roughly \$13.50 per client visit, \$25 per client seen at least once in the year, and almost \$60 per CYP achieved in the year.

This finding is consistent with the earlier finding by Graves (CDC Gambia trip report, November 1983) that client loads are very low, relative to staff inputs in GFPA facilities, suggesting that more attention needs to be given to activities resulting in higher utilization by new and continuing users. This suggestion is not new to the GFPA and underlies its present desire to conduct studies on motivational impacts and characteristics of users/discontinuers, as well as on costs of subprojects.

#### C. Commodities

Contraceptive supplies and family planning equipment are maintained in a storeroom at the GFPA headquarters. The storeroom also serves as a general repository for nonfamily planning items, such as bags of cement, which ideally should not be in proximity with contraceptives.

Actual stock inventories were compared with tally card records. A number of discrepancies were noted and discussed with the stores clerk. The main source

of these discrepancies was a delay, in some instances of over 2 months, in updating tally cards after requisitions from clinics had been received and filled. The need for prompt and constant updating of records was discussed with the stores clerk, as was the desirability of maintaining contraceptive supplies separately from other materials in storage.

At present use rates, there appears to be no imminent shortage of IUCDs and Depo-Provera, and there is a surplus of condoms, with almost 4 years' supply at 1986 use rates. Pill supply, however, may become a problem, as the 7,900 cycles of Femenal (remaining from 12,000 cycles obtained in 1986 from AID/Senegal) will last barely 4 more months. Quantities on hand at other GFPA clinics were not determined. The small remaining stock of Noriday expired in June 1986. However, there are adequate stocks of orals available at the MOH, which could be "borrowed," and the local UNFPA office is in the process of redirecting some orals originally intended for the MOH, which subsequently decided it did not want them, to the GFPA. UNFPA, unfortunately, had no readily available record of the quantity nor brand of these pills.

#### D. Ministry of Health (MOH)

An attempt was made to look into the status of commodities at the MOH, and particularly to verify AID records of FPIA shipments of condoms, pills, and IUCDs to the Gambian FP program. Our meeting with the chief pharmacist provided a useful, though incomplete, start to this process. In terms of verification of FPIA shipments for past years, we found little direct correspondence between records of shipments and receipts, though records since April 1985 appear to have been maintained carefully. The main problem was that we were unable to obtain a complete picture of receipts by and issues from the Central Medical Stores (CMS), since records prior to April 1985 were not transferred. These records remain with Bertha M'Boge, the Nursing Sister, who coordinates the MOH's MCH/FP Division.

I contacted Sister M'Boge by telephone from USAID to request a brief meeting with her to look at these records, and to obtain some information on past family planning activities and performance levels. Unfortunately she declined to see us, since she felt she was given insufficient advance notice by USAID and me, even though I tried to explain the circumstances requiring such short notice to her. We were therefore unable to incorporate information from these earlier time periods into our assessment of commodity flows. Similarly, we were unable to obtain any information on reported MOH family planning achievements, since this information also seemed to be available only through Sister M'Boge's files.

One encouraging finding was that the recommendations for incorporating family planning supplies into the overall CMS-MOH pharmaceutical management system, emanating from an AID/REDSO supported AFRICARE consultancy conducted in July-August 1986 by Mr. D. Gabriel, appear to be being implemented. These well thought-through recommendations included fairly extensive modifications of ordering, storage, and reporting procedures and forms.

Mr. Gabriel also performed a physical inventory of contraceptives at the CMS. Our comparison of his inventory of July 10, 1986, to CMS inventory records of March 20, 1987, indicated that the only method which has been significantly

depleted is the Copper T 200 IUCD, of which only 600 remain in stock at the CMS, following distribution to other clinics of 1,200 between July and October 1986. Without access to reported performance figures for IUCD insertions, it is not possible to know how many months of supply this represents. However, anecdotal evidence suggests that, particularly given the substantial remaining stocks of other IUCDs (Lippes Loops and Saf-T-Coils), there is no imminent danger of stockouts.

#### V. POSSIBLE NEED FOR FOLLOWUP

By virtue of its small size and relatively modest family planning efforts, The Gambia does not rank high among AID's family planning priority nations. However, this brief assignment and discussions with AID staff and others in The Gambia, did suggest that to the extent that such visits could be made in conjunction with other regional travel, a useful function could be served by occasional visits to check on progress of the program, to assist with development of overall management and information systems, and to assess commodity status and future contraceptive requirements. The question was specifically raised whether it might be possible for me to make a followup visit later this year. Such a visit would include explicit attention to the need to bring together information from the two main service providers, the MOH and the GFPA, to provide a more comprehensive view of overall program coverage and lacunae.

I indicated that such a request for CDC assistance would need to come from the concerned agencies (MOH and GFPA), through AID/Banjul to AID/W and CDC, and could probably be acted on no earlier than late summer, even if such a request were soon to be forthcoming. In subsequent conversations with AID/W, the possibility of a visit around October, in conjunction with another West African trip, was discussed. This would obviously require a request from The Gambia, to be received preferably at least 3 months prior to the proposed dates. We would further urge, in the interest of efficient time utilization, that if such a request is made, it be arranged that the population intern be assigned to work with the consultant during this assignment. This would also establish a mechanism for effective followup and liaison with AID/Banjul.



J. Timothy Johnson, Dr.P.H.