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**FINAL EVALUATION OF THE GHANA
CONTRACEPTIVE SUPPLIES PROJECT
NO. 641-0109**

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Fieldwork

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Project Identification Data

1. **Country: Ghana**
2. **Contraceptive Supplies Project**
3. **Project Number: 641-0109**
4. **Critical Project Dates:**
 - Grant Agreement: September 19, 1985**
 - Grant Agreement Amend: March 27,1986**
 - Grant Agreement Amend: March 31,1987**
 - Final Obligation Date: March 31,1987**
 - Proj. Asst.Compl.Date: March 30,1989**
 - PIL-5 Extended PACD to: June 18,1990**
 - PIL-8 Extended PACD to: June 18,1991**
 - PIL-11 Extended PACD to:June 30,1992**
5. **Project Funding (\$ millions):**

USAID Bilateral:	\$7.0
A.I.D. Regional Funds:	1.0
A.I.D. Central Funds:	2.5
Government of Ghana Counterpart Funds:	<u>3.0</u>
	\$13.5

Note: Estimate of central funds is through 3/88.

6. **Mode of Implementation:**
 - USAID Bilateral: Host country contract(DANAFCO, Ltd.) and USAID direct procurements**
 - A.I.D. Regional: Operational program grant and buy-ins to centrally funded projects**
 - A.I.D. Central: Subagreements/subcontracts under centrally funded projects**
7. **Project Designers:**
 - REDSO Technical and Project Development Officers**
 - Mission Program Staff**
 - AFR/TR/HPN Personnel**
 - Private Consultants**
 - Government of Ghana Officials**
9. **Previous Evaluations:**
 - Price Waterhouse Management Capability Assessment, October 1985**
 - Population Technical Assistance Project Midterm Evaluation, March 1988**

Glossary

ACNM	American College of Nurse/Midwives
AFR/TR/HPN	Bureau for Africa/Technical Resources/Health, Population, and Nutrition
A.I.D.	United States Agency for International Development
AIDS	acquired immune deficiency syndrome
CBD	community-based distribution
CCPR	couple year of protection contraceptive prevalence rate
CDC	Centers for Disease Control
CPR	contraceptive prevalence rate
CPS	Contraceptive Prevalence Survey
CYP	couple years of protection
DHS	Demographic and Health Survey
EPI	Expanded Program on Immunization
FP	family planning
FPLM	Family Planning Logistics Management (project)
GBC	Ghana Broadcasting Corporation
GOG	Government of Ghana
GSMP	Ghana Social Marketing Project
GRMA	Ghana Registered Midwives Association
IEC	information, education, and communication
IMPACT	Innovative Materials for Population Action (project)
IUD	intrauterine device
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
JSI	John Snow, Inc.
KAP	knowledge, attitudes, and practice
KATH	Komfo Anokye Teaching Hospital, Kumasi
MCH/FP	maternal child health/family planning
MIS	management information system
MOH	Ministry of Health
MWIFA	married women in fertile age
MWRA	married women of reproductive age
NGO	non-governmental organization
ORS	oral rehydration salts
PACD	project assistance completion date
PCS	Population Communication Services (project)
PIL	project implementation letter
PIO/T	project implementation order/technical
PIP	Population Impact Project
POPTECH	Population Technical Assistance Project
PPAG	Planned Parenthood Association of Ghana
RAPID	Resources for Awareness of Population Impact on Development (project)
REDSO	Regional Economic and Development Support Office
TBA	traditional birth attendant
TOT	training of trainers
SOMARC	Social Marketing for Change (project)
UNFPA	United Nations Population Fund

USAID
VFT
VSC

United States Agency for International Development (mission)
vaginal foaming tablets
voluntary surgical contraception

Executive Summary

Introduction

The Government of Ghana and USAID/Ghana approved the Contraceptive Supplies Project on September 19, 1985, with life-of-project funding of \$7.0 million over four years. The original project assistance completion date of March 30, 1989, was extended to June 30, 1992, to allow for completion of the scope of work.

The purpose of the project was to increase the voluntary use of safe, effective, and appropriate modern contraceptive methods by Ghanaian couples. This was to be accomplished by making an adequate supply of contraceptives and family planning services available on a continuing basis through the existing delivery network of the Ministry of Health (MOH), and through the development of the Ghana Contraceptive Social Marketing Program (GSMP) in the private sector. Contraceptive use by clients at MOH project sites was estimated to rise from approximately 2 percent of the women in fertile age in 1984 to approximately 6 percent in 1988. The social marketing portion of the project was expected to expand following its initiation to a level of approximately 7 percent of the women in fertile age in 1988. These efforts, combined with activities of various non-governmental organizations, were expected to bring the contraceptive prevalence rate to approximately 16 percent by 1988.

During the implementation of this project, Ghana marked the twentieth anniversary of its adoption of a national population policy with an action plan to reduce the rate of population growth to 1.75 percent by the year 2000. In those 20 years many attempts were made both in the private and the public sector to establish family planning programs. None of them resulted in a large-scale national or even regional effort, and none has had any measurable effect on Ghana's fertility rates. Over the 20-year period, Ghana's population has doubled in size and the youthful population has greatly expanded the numbers entering the fertile ages.

The Contraceptive Supplies Project is the most promising effort to date to develop a national family planning program, but it has faced difficult problems in meeting its objectives. Socio-economic conditions had deteriorated to an extremely low level in the early 1980s, and family planning program efforts had virtually disappeared. Consequently, this project began with all the start-up problems of a new activity. Some delays were inevitable, but in the last two years the level of activity has substantially increased. Several aspects of outstanding program implementation are particularly noteworthy. The breadth of the training accomplishments, both in Ghana and abroad, have provided family planning and communication skills to personnel numbering in the thousands. They constitute a network of support for men and women throughout Ghana who are seeking information and modern methods to improve their family welfare and reproductive health through family planning. The expansion of the GSMP's points of delivery for barrier methods and oral contraceptives and brand-specific advertising in the mass media clearly reflect the improved environment of family planning policy and prepare the way for a more rapidly growing effort in the follow-on Ghana Family Planning and Health Project.

The project was not designed to nor did it achieve contraceptive use rates consistent with either public health coverage requirements or demographic objectives. As Ghana's national family planning program is poised for the next phase in increasing the availability and utilization of family planning

services, it will need to build on its positive points and resolve the technical, financial, managerial, and logistics problems that have substantially limited progress in the present period.

Major Project Accomplishments

- The number of family planning service delivery points has expanded from an estimated 87 clinics in the public health system in 1987 to 584 public health clinics, 238 private sector midwives, and almost 3,000 traditional birth attendants (TBA) (who are only marginally involved in the provision of barrier methods at the community level) in 1990.
- Improvements in the MOH management information system (MIS) have been reported with almost 100 percent timely reporting from the clinics, districts, and regions using the simplified forms developed with project assistance.
- There has been a reasonably good 1.5 percentage point increase in contraceptive prevalence in each of the last two years. (It should be borne in mind, however, that this is at a very low level and not one that will have much impact on public health or demographic parameters.)
- Important progress has been achieved in developing the GSMP, significantly expanding the number of delivery points for products, and improving record keeping and reporting. Achievements include the following:
 - the creation and expansion of a private sector delivery system with 3,500 retail outlets for barrier methods and oral contraceptives through training for pharmacists and chemical sellers;
 - the use of advertising and marketing to increase consumer awareness of GSMP products and volume sales increases of 29 percent between 1988 and 1990; and
 - the development of an appropriate program of market research with seven relevant studies already completed through contracts with a local market research firm, MSRI, in 1990 and 1991 alone.
- The project has used training; information, education, and communication (IEC) activities; improvements in the quality of service offered at MOH service centers; and population policy development to create awareness and desire to use family planning services. Some noteworthy accomplishments were made in these areas:
 - approximately 170 persons have been trained abroad in short courses in family planning service delivery skills, management, IEC, social marketing, child survival, reproductive health, and public health;
 - in-country training has been provided for 63 master trainers and 307 supervisors to train 2,949 TBAs in improved prenatal and child delivery practices along with concepts of family planning; 238 private sector midwives have been trained in family planning skills and in private enterprise business practices; 435 public sector midwives have been trained in family planning service delivery skills; approximately 20 physicians and 50 interns have been trained in minilaparotomy and 50 private sector physicians have been trained in IUD insertion; 689

persons have been trained in logistics and MIS; and 5,154 Level B health service providers have been trained in IEC and family planning;

— improvements have been made in the quality of care, as seen in such aspects as having more consistently available in the health centers family planning service providers who are better prepared to communicate with clients and to provide a wider choice of contraceptive services to respond to client needs;

— the public sector IEC campaign has increased support for Ghana's family planning initiative and provided some excellent informational materials for health care professionals and consumers alike; and

— the Population Impact Project has provided leadership education seminars, eight issues papers on population and family planning and their relation to socio-economic development and family health and welfare, a computerized visual presentation depicting these relations, and a series of radio and television spots and newspaper articles, all of which have contributed to the regeneration of interest in pursuing the nation's positive population policy.

Issues in Project Performance

Against the project target of a 13 percent increase in use of modern contraceptive methods for the combined MOH and GSMP contributions, use of modern contraceptive methods in the MOH and GSMP components of the project has increased to about 6.2 percent of the women of reproductive age. Especially in the light of such impressive performance in some of the supporting elements of family planning described above, one must wonder why there has not been more progress in achieving contraceptive prevalence goals. A number of factors have contributed to this outcome, key among them being the following:

- the low level of national government participation in the family planning program as would be expressed in budgetary allocations and a high-level organizational position within the MOH commensurate with the importance of family planning in improving health and economic conditions in Ghana and reducing the rapid rate of population growth;
- the limitations on improved project management within the MOH as there are no full-time professionals assigned family planning program responsibility either at the central, regional, or district levels in the decentralized, integrated system for the delivery of health care, an approach that has not been successful for family planning service delivery worldwide;
- the limitations on growth in the GSMP as insufficient provision was made in the project design for management and sales personnel dedicated solely to achieving GSMP's social objectives within the institutional structure of a private commercial enterprise whose primary responsibility is to carry on a business other than marketing family planning products;
- the private sector delivery system's not being able to deliver products consistently and reliably to the retail outlets in the system;
- the limitations in USAID staffing that have forced priority to be given to new project development, leaving some implementation actions of the Contraceptive Supplies Project unattended;

- the serious problems of commodity supply and stock-outs that must be traced to failures on the part of A.I.D./Washington, USAID, and the Government of Ghana in procurement and port clearance, as well as MOH management oversight in inventory control and failure to create an internal supply system that delivers commodities to the clinic level;
- the need for a systematic evaluation of the training received by the 5,154 Level B personnel;
- the need for approval of the pre-service family planning curriculum in the Schools of Midwifery;
- the regulatory restrictions on oral contraceptives that effectively preclude distribution by the program outside the confines of clinics or pharmaceutical channels;
- the limited availability of voluntary surgical contraception;
- the inadequate service delivery emphasis in the areas of highest population density; and
- the limitations in funding the IEC campaign to provide a consistent, widespread mass media campaign to help convert awareness of family planning to effective use.

Recommendations

The following highlights and summarizes priority recommendations found in the body of the report and compiled in Annex B.

1. USAID and the Government of Ghana should take the necessary action to complete the unfinished business of the Contraceptive Supplies Project which is critical for developing a baseline and initiating the new project, making strategic decisions in developing training plans, and assuring adequate supplies of contraceptives to the service delivery channels. These actions are as follows:
 - a) carrying out an interim Contraceptive Prevalence Survey or advancing the date of the next Demographic and Health Survey,
 - b) completing the planned evaluation of training and institutionalizing family planning training in pre-service curricula, and
 - c) solving the problems of procurement, shipment monitoring, and delays in removing contraceptives from the port.

2. USAID and the Government of Ghana should go forward with the implementation of the new project, but together with the prime contractor should review the assumptions, targets, and management policies in the light of the findings of this evaluation. Of signal importance to securing project success consistent with the Government of Ghana's stated policy of fertility reduction, the following actions are considered of the highest order of priority:
 - a) The demonstration of national support for this population policy through the inclusion of support for family planning activities as line items in both the capital and recurrent cost budgets of the national government.

- b) The demonstration of A.I.D. support for the family planning program through the addition of two professional staff in its USAID Health, Population, and Nutrition Division; by expeditious arrangements for resident technical assistance personnel in the Project Management Unit; by the long-term commitment of adequate resources to provide for a strongly managed and aggressive social marketing project; and by support of actions within the MOH designed to place greater institutional and programmatic emphasis on family planning within the health system.
- c) The development of coordination and support mechanisms for the social marketing project by USAID and the Government of Ghana that enhance rather than hinder development of the private sector as a reliable resource for consumers wishing to adopt family planning practices. This involves understanding the priorities and limitations of the private sector, while supporting it in applying its strengths to the effort; the development of overall policy guidelines that encourage the expansion of the distribution network; and the implementation of procedures to remove bureaucratic or regulatory constraints on project progress.
- d) The strengthening of the maternal and child health/family planning program units at the national and regional levels with staff, space, and equipment to provide adequate full-time professional attention to family planning program planning, training, MIS, inventory control, and monitoring of program performance.
- e) Continuing support from both USAID and MOH for the MOH's Health Education Department to allow it to plan, manage, and evaluate a broad IEC campaign in coordination with GSMP, the Planned Parenthood Association of Ghana, and others with heavy financial commitment to mass media IEC.
- f) The exemption of oral contraceptives from pharmaceutical regulation, based on the review of worldwide research on the safety of newer contraceptives, their non-contraceptive health benefits, and the relatively much higher risk to mothers and children of unwanted or unhealthy pregnancies.
- g) Intensification of service delivery in areas of highest population density through high-caseload, all-methods private clinics and expansion of GSMP and community-based distribution in these areas of high density, with easier access to and more readiness for family planning.
- h) Creation of a sole-purpose commodity delivery system to ensure reliable delivery of family planning products to retail outlets within the proposed social marketing unit, and an equally sole-purpose commodity delivery system within the MOH.

Lessons Learned

1. The development of a national family planning program is a more labor intensive undertaking than is often recognized by those who allocate personnel either in USAID or in host country institutions.
2. A corollary requirement is the need for the project to support sufficient personnel for management and implementation of private sector social marketing activities until the growth of

effective demand has demonstrated sufficient commercial viability to attract financial and personnel investment by the local cooperating firm.

3. Demand creation efforts must involve policy development actions with policy-making groups and with program implementation policy makers, and must also involve the training of program personnel both in service delivery and communication skills.

4. An effective national family planning program requires national government commitment that goes beyond policy statements and is effectively demonstrated by allocations of financial and personnel resources consistent with the critical importance of the effort.

5. The Ghana program has demonstrated the validity of a lesson learned elsewhere — that there can be no quality family planning services without a full and constant supply of contraceptives.

6. The requirements for local cost financing must be recognized more clearly and addressed more effectively than is often the case (perhaps as excessive emphasis is placed on demonstrating low recurrent cost requirements and the potential for early self-sufficiency).

7. Social marketing programs must realistically appraise the practical commercial objectives of the cooperating private sector enterprise.

8. It is unlikely that a program will succeed with the kinds of constraints on the use of oral contraceptives which derive from a pharmaceutical classification as "dangerous" drugs.

9. Program objectives of reaching a higher percentage of the population with family planning services will be more effectively and more efficiently reached by intensification of effort in the areas of greater population density, easier access, and more readiness to make use of family planning services.

1. Introduction

1.1 Overview of the Project

The Government of Ghana (GOG) and USAID/Ghana approved the Contraceptive Supplies Project on September 19, 1985, with life-of-project funding of \$7.0 million over four years. At the time of project approval, \$2.18 million was obligated. On March 27, 1986, and again on March 31, 1987, the grant agreement was amended to provide \$3.0 million and \$1.82 million, respectively, to fund the project fully. These amendments also made minor changes in the project description.

The Ministry of Finance and Economic Planning, International Economic Relations Division signed the project agreement for the GOG. It delegated management of the public sector component of the project to the Ministry of Health (MOH) and management of the private sector component of the project to a commercial firm, DANAFCO, Ltd., under contract to the Ministry of Finance and Economic Planning.

The project purpose was to increase the voluntary use of safe, effective, and appropriate contraceptive methods by Ghanaian couples. This was to be accomplished by making an adequate supply of contraceptives and family planning services available on a continuing basis through the existing service delivery network of the MOH and through the development of a Contraceptive Social Marketing Program (now called the Ghana Social Marketing Project [GSMP]) in the private sector. To achieve these goals, the project was to focus on the following five basic elements:

- contraceptive inputs into the MOH maternal and child health/family planning (MCH/FP) system;
- improvements in the MOH contraceptive distribution and management systems;
- staff training to improve institutional efficiency;
- information, education, and communications (IEC) efforts for intended beneficiaries; and
- a Contraceptive Social Marketing (now GSMP) network.

Table 1 on the next page shows the original project budget and the final changes in the budget which were made on November 12, 1991.

The important changes over the six-year period were to decrease the budget for contraceptives by approximately 40 percent, to increase the IEC budget elevenfold, and to increase the training budget sevenfold. Although it appears that the technical assistance budget was reduced from a very low level to an even lower level, in fact it was substantially increased, but the costs are subsumed in the training and IEC budgets.

Table 1**Project Budget
(in US \$000s)**

Item	Original Budget	1991 Amendment
Contraceptives	5,527	3,290
IEC	80	927
Vehicles	180	170
Training	285	1,935
Evaluations, Surveys	150	439
Technical Assistance	212	117
Contingency	566	—
Program Support	—	119
Total	7,000	6,997

Source: USAID/Ghana

In addition to USAID bilateral support, by the time of the midterm evaluation in March 1988, \$1 million of regional funds and approximately \$2.5 million of A.I.D. central funds were provided to Ghana in support of the project objectives. Information on the final level of central funds provided was not available at the time of this evaluation.

During the implementation of the project, Ghana marked the twentieth anniversary of its adoption of a national population policy with an action plan to reduce the rate of population growth to 1.75 percent by the year 2000. Over those 20 years many attempts were made in both the private and the public sector to establish family planning programs. Some of these were reasonably successful in limited areas, and pointed to possibilities for more vigorous programs. None of them resulted in a large-scale national or regional effort, however, and none have had any measurable effect on Ghana's fertility rates. Over the 20 year period, Ghana's population has doubled in size and the youthful population has greatly expanded the numbers entering the fertile ages.

The Contraceptive Supplies Project is the most promising effort to date to develop a national family planning program. In many ways, the project could almost be considered a brand new effort. Socio-economic conditions had deteriorated to an extremely low level in the early 1980s, and family planning program efforts had virtually disappeared. The project began with all the start-up problems of a new activity. Some delays were inevitable, but in the last two years the level of activity has substantially increased.

The breadth of the project's training activities, both in Ghana and abroad, have provided family planning and communications skills to personnel numbering in the thousands. These trained personnel constitute a network of support for men and women throughout Ghana who are seeking information and modern methods to improve their family welfare and reproductive health through family planning.

The expansion of the GSMP's points of delivery for barrier methods and oral contraceptives and brand-specific advertising in the mass media clearly reflect the improved family planning policy environment and prepare the way for a more rapidly growing effort in the follow-on project.

The project was not designed to nor did it achieve contraceptive use rates consistent with either public health coverage requirements or demographic objectives. As Ghana's program is poised for the next phase in increasing the availability and utilization of family planning services, it will need to build on its positive points and resolve the technical, financial, managerial, and logistics problems that have substantially limited progress in the present period.

The next phase of USAID support to the family planning program will be provided through the follow-on project, the Ghana Family Planning and Health Project. This \$30 million six-year project was authorized by USAID on February 2, 1991, and is now in the initial stages of implementation. The project includes program assistance aimed at policy change and a project component directed toward activities to improve the capability and increase the capacity of health care providers to deliver family planning and MCH services. In addition, contraceptives will be supplied. The project expects to continue many of the present activities in the public sector but calls for substantially more emphasis on the private sector. The USAID management approach will be considerably different with a prime contractor in-country organizing project management and social marketing units. The conservative target for increase in contraceptive prevalence is that by the end of the project the modern contraceptive prevalence rate will have risen to 15 percent nationwide.

1.2 Evaluation Scope of Work

As indicated in the scope of work (Annex D), the objectives of the evaluation were

- to focus on project success in achieving training, sales, and contraceptive use objectives;
- to determine the lessons learned from the implementation of the project that are important for implementing the follow-on project; and
- to examine the extent to which the recommendations of the midterm evaluation were implemented and the extent to which they modified project accomplishments.

Specific questions were included in the scope of work to guide the evaluation team's consideration of these objectives. Some studies that may have been contemplated when the scope of work was written had not been carried out and some data available was not at a level of disaggregation to allow more than subjective analysis. Also, some project activities (such as the oral rehydration salts [ORS] activities) were so recently begun that the team could only speculate as to their impact. Therefore, it was agreed that several of the questions could not be answered with the precision of measurement implied. It was also agreed that insofar as these questions could be answered, they would be

addressed as part of the functional sections of the evaluation report and not according to the outline of the scope of work.

1.3 Evaluation Methodology, Timing, and Team Composition

Within the limits of the time and data available, the team addressed the issues above through review of various reports and other evaluations available at USAID, the MOH, DANAFCO, and related organizations; through interviews with personnel in these institutions and the Planned Parenthood Association of Ghana (PPAG); and field visits to four regions of the country. Preliminary findings were shared with USAID, the Government of Ghana, and GSMP midway in the evaluation. A presentation of the conclusions and recommendations was given for USAID, MOH, and DANAFCO before the team left the country. Discussions were also held with MOH, the MOH Health Education Division, and DANAFCO after the presentation to clarify any points of confusion.

The team was composed of Population Technical Assistance Project (POPTECH) consultants William Bair, Olivia Holmes, and Juan Londono for approximately four weeks, November 17 through December 15; John Paul James, REDSO population officer, for three weeks; and Ruth Gyang, from the Government of Ghana, for the field visits and subsequent consultation. William Bair served as the team leader, organizing the overall evaluation and focusing on quality of care, management, and policy issues. Juan Londono dealt specifically with the impact of the project on contraceptive use and availability, logistics, and the management information system (MIS); he also assisted with the overall policy considerations. Olivia Holmes focused on the social marketing component and IEC, but also contributed in management and policy considerations. John Paul James contributed specifically in the area of training and also assisted with IEC, impact, management, and policy issues. Ruth Gyang made a valuable contribution in helping the team understand what was seen and heard especially in the area of training and quality of care. Her critique of team conclusions and recommendations gave an important Ghanaian perspective to the findings. Lawrence Darko and Joanna Laryea of USAID/Ghana provided assistance with field visits and in securing essential information.

2. Service Delivery Impact

2. Service Delivery Impact

2.1 Project Objectives

The project paper states that "the project purpose is to increase the voluntary use of safe, effective, appropriate [modern] contraceptive methods by Ghanaian couples. Contraceptive use by clients at MOH project sites is estimated to rise from approximately 2 percent of the women of fertile age in 1984 to approximately 6 percent in 1988. The social marketing portion of the project is expected to expand following its initiation to a level of approximately 7 percent of the women in fertile age in 1988. These efforts, combined with activities of various non-governmental organizations (NGO), should bring the contraceptive prevalence rate to approximately 16 percent by that time."

2.2 Midterm Evaluation Findings

As little had been accomplished by the time of the 1988 midterm evaluation that would have a direct effect on user numbers, the evaluation had little to say on this subject. It did note ". . . indications are that the project will succeed in achieving its purpose of increasing the use of . . . contraceptive methods. . . . Center for Disease Control (CDC) estimates that the project through 1989 will lead to a contraceptive prevalence rate of 15 percent."

2.3 Difficulties Encountered in Measuring Progress

It is difficult to evaluate the extent to which goals have been achieved. In combination with contraceptive distribution figures, a contraceptive prevalence survey (CPS) can produce estimates of project performance. No CPS was carried out at the end of the project, however. Statistics on distribution from different sectors within the program are not fully comparable. There are problems in the way detailed targets were expressed as goals in the project paper. In addition to the basic contraceptive prevalence goals projected, the project paper contained targets in terms of users and couple years of protection (CYP). There was not a good correlation, however, between these project paper user targets and the expressed goal of contraceptive prevalence. Therefore, this evaluation focused on contraceptive prevalence using estimates of CYP provided as the best measure available. See Annex E for a more detailed explanation of these problems.

Similar problems may be encountered in future evaluations. The targets of the follow-on Ghana Family Planning and Health Program do not clarify what portion of the contraceptive prevalence rate (CPR) is to be expected from the public and private sector and the degree to which the PPAG is to be involved. Neither do the quantities of contraceptives projected to be distributed match with the expected CPR or with the dollar amounts projected for their purchase.

2.4 Distribution Trends and Accomplishments Related to Project Targets

Since the targets for the project were not revised to reflect the three-year extension of the project, targets for 1988 are assumed to be the targets to be achieved during 1990. The comparison of the original target with the achievement in 1990 indicates that 47 percent of the targeted CPR — 6.2 versus 13.2 respectively — was reached. See Table 2 below.

Table 2

Contraceptive Prevalence Rate Project Targets and Achievements

Sector	Targets			Achievements	
	1986	1987	1988	1990	%
MOH	3.5	5.7	6.2	3.2*	52
GSMP	1.0	4.5	7.0	3.0*	43
Total	4.5	10.2	13.2	6.2	47

Source: Based upon data provided by MOH MCH/FP program and GSMP.

Actual 1990 CYP contraceptive prevalence rate achieved is derived by dividing CYP generated by the number of married women in fertile age (MWIFA) times 100.

At this stage of the project, the combined effect of the two project components (MOH and GSMP) is a CPR in excess of 6 percent in three regions; the rest of the regions have very low CPRs.

Table 3

Contraceptive Prevalence Rates by Region

Region	Prevalence Rate %	Region	Prevalence Rate %
Greater Accra	16.2	Central	3.8
Ashanti	8.5	Volta	3.8
Brong Ahafo	6.3	Upper East	2.5
Western	4.7	Northern	2.2
Eastern	4.4	Upper West	1.5

Source: Based upon data provided by the MOH.

The project target goal of a 13.2 percent CPR implies an average annual increase of four percentage points for the combined MOH-GSMP contribution to the national prevalence rate. Although this goal is overly optimistic for a program at the initial stages of its development, it should have been more realizable by 1990. The CPR projected for all sources of the project, including the PPAG, was 15.6 percent for 1988.

Although imperfect, the CYP-generated contraceptive prevalence rate (CCPR) is one measure of project impact. Using this rate, for the overall program the contraceptive prevalence rate may be around 8 percent for 1990, as compared to about 5 percent in 1988. This shows an average annual increase of 1.5 percentage points per year in these two years, which is reasonable for a program in the initial stages of implementation.

In spite of the problems associated with the accuracy of estimating prevalence using CYPs, the difference between the rates for 1988 and 1990 may still show a trend, since CYP-1988 and CYP-1990 have similar inaccuracies. In general, the family planning program of Ghana has had some success in distributing contraceptives during the past two years, but it started at a low level. See Table 4 below.

Table 4
CYP Generated by Contraceptives Distributed
by Program Sector 1987 -1991

Sector	1987	1888	1989	1990
MOH	13,836	26,585	63,809	93,682
GSMP	52,674	66,879	73,205	85,880
Total Project	66,510	93,464	137,014	179,562
PPAG	68,858	64,364	69,863	58,893
Total Program	135,368	157,828	206,877	238,455

Source: Based upon data provided by the MOH MCH/FP program, GSMP, and PPAG (based on figures collected by USAID Health, Nutrition, and Population Officer).

The program became more active during 1988 in both the MOH and GSMP sectors, and has continued growing until recently. This growth has been due to the incorporation of more trained people in the MOH during 1988 and 1989, and to the introduction of new products (Kamal, a vaginal foaming tablet and Norminest, an oral contraceptive pill) in the GSMP during 1987. Although the effects of these additions to the product line began to be seen in sales data in 1988, some signs of stagnation also started to be seen. The graph in Annex F shows that the program had two periods of stagnation that lasted for a short while. The program was able to restart the upward trend during these periods by adding more outlets in both the MOH and GSMP projects, and by introducing new products in the GSMP.

2.5 Expansion of Access and Regional and Institutional Differences in Productivity

2.5.1 Number of Service Providers Trained

Potential family planning service delivery locations experienced a large expansion during the implementation of the project. About 238 private sector members of the Ghana Registered Midwives Association (GRMA) and about 5,000 traditional birth attendants (TBA) have been trained in family planning. All the nurses, including 435 public sector midwives, in an additional 500 MCH clinics have been trained. Even though the GSMP project has been concentrated in some of the regions, its inclusion in the family planning program has meant considerable additional expansion with more than 3,000 pharmacists and chemical sellers trained to dispense barrier methods and oral contraceptives. Although based on incomplete available information, Table 5 shows the expansion of family planning services in the regions.

Table 5

Expansion of the Family Planning Program

Region	MCH/FP Clinics		TBAs Trained	Potential GSMP Locations**
	1987*	1990		
Greater Accra	—	50		474
Ashanti	—	69		608
Eastern	—	119		573
Brong Ahafo	—	55	600	450
Volta	—	110	561	269
Central	—	48	568	321
Western	—	52		419
Northern	—	37	620	193
Upper East	—	15		
Upper West	—	29	600	129
Totals	87	584	2,949	3,436

* Source: Based upon data provided by the MOH MCH/FP program and GSMP.

* Regional breakdown not available

** The majority of these GSMP locations have already received the training required and there is an ongoing program to train the rest.

2.5.2 Productivity by Region

MOH clinics are distributed widely throughout the country, with many clinics providing services to only a few people. The national average shows that one clinic produces less than one CYP per day. In the Greater Accra Region, which has the highest productivity, an average clinic serves 27 clients per month in family planning. In the Upper Western Region, an average clinic produces a bit more than 3 CYPs per month and the same is true of the Volta Region.

Table 6

Productivity of the MCH/FP Clinics by Region, 1990

Region	Number of Clinics	Estimated No. MWRA	CYP	CYP Generated per Clinic (in 000's)	CCPR Prevalence %
Ashanti	69	488	21,157	307	4.34
Brong Ahafo	55	282	17,591	320	6.25
Central	48	267	9,665	201	3.63
Eastern	119	392	967	81	2.47
Greater Accra	50	334	16,256	325	4.87
Northern	37	272	5,001	135	1.84
Upper East	15	180	4,122	275	2.29
Upper West	29	102	1,172	40	1.15
Volta	110	276	4,909	45	1.78
Western	52	270	3,743	72	1.39
Totals	584	2,863	84,583	160	3.25

Source: Based upon data provided by the MOH MCH/FP program.

GSMP has concentrated its social marketing efforts in the southern regions of the country, primarily in the Greater Accra and Ashanti Regions, where the 1990 sales were 44 percent and 24 percent, respectively, of the total CYP generated by this effort. (See Table 7.)

Table 7

Distribution of Contraceptives by GSMP by Region, 1990

Region	Estimated No.MWRA (in 000's)	CYP (Users)	Percent Distribution	Prevalence % MWRA
Ashanti	488	20,415	23.8	4.2
Brong Ahafo**	282	156	0.2	—
Central**	267	688	0.8	0.2
Eastern**	392	7,439	8.7	1.9
Greater Accra	334	37,662	43.8	11.3
Northern	272	1,095	1.3	0.4
Upper East	180	283	0.3	0.2
Upper West	102	40	—	—
Volta	276	5,450	6.3	2.0
Western	270	8,777	10.2	3.3
Totals	2,863	82,005*	95.40	3.0

Source: Based on data provided by GSMP.

* Includes 3,874 CYPs generated by contraceptives distributed to six sub-depots.

** Brong Ahafo, Central, and Eastern Regions may be receiving supplies from other regions.

The possibilities of increasing performance at MOH clinics are slim, since other health activities of the MCH/FP program are considered priority and absorb most of the available time. In the MOH Annual Report of 1990 and the Semi-Annual Report for the first six months of 1991, the family planning effort represents 4 percent and 3 percent, respectively, of the total activities of the MCH/FP program. In addition, other resources such as program management personnel and means of transportation are limited, and adequate support with supervision and supplies and district management is not being provided.

2.6 Contraceptive Mix

The project offers a variety of contraceptive methods. A.I.D. provides the MOH with oral contraceptives (Lo-Femenal and Ovrette), IUDs (Cu-T 330), vaginal foaming tablets (Conceptrol), and condoms (Sultan). Norminest (now being replaced by Secure [Norquest]), the Panther condom, and Kamal vaginal foaming tablets are distributed through the GSMP effort, and the Protector

condom is soon to be introduced.¹ The total family planning program in Ghana also distributes Micronovum, Microgynon, NeoSampooon and Depo Provera, which are donated by UNFPA. (See Table 8). Voluntary surgical contraception (VSC) is a small part of the total activity of the program (2 percent), and is offered only in MOH facilities. Depo-Provera and IUDs have participation rates of 8 and 12 percent, respectively.

Table 8
Percent Distribution of CYP per Method
1990

Method	MOH	GSMP	PPAG	Total
Orals	39.8	39.7	39.3	39.6
VSC	6.8	—	—	2.7
IUD	18.4	—	20.1	12.2
Depo Provera	16.7	—	6.6	8.2
Condom	9.9	41.9	25.6	25.3
Vaginal Tablet	8.4	18.4	8.4	12.0

Source: Based upon data provided by MOH, GSMP, and PPAG.

Traditional contraceptive methods, usually not provided by the program, account for much of the total contraceptive prevalence rate in Ghana. The 1988 Demographic and Health Survey (DHS) reported a specific prevalence rate for these methods of 6.8, which was higher than the rate for modern methods at that time.

2.7 **Conclusions**

1. The difficulties encountered in attempting to measure project effectiveness confirms the need for a Contraceptive Prevalence Survey and the need to review the targets proposed for the follow-on project.

2. The project has seen growth in the contraceptive prevalence rate, but not enough to reach the GOG population growth rate target nor to affect the crude birth rate. The possible trend toward an annual increase of 1.5 percentage points as indicated by the CYP figures for 1988 and 1990 does not mean that the program is efficient or cost effective as far as family planning is concerned. Although the GOG has valid reasons for expanding health services in geographical terms, there is also an urgent need to speed the process of adopting family planning methods to reduce fertility to

¹GSMP received 28,900 IUDs between 1988 and 1989, with the intent of extending distribution through the GRMA registered nurse/midwives in private practice. However, of the original 5,000 distributed to the nurses on credit, the vast majority were returned because the nurses were unable to sell them; 25,160 IUDs were ultimately redistributed to the MOH.

achieve GOG population policy goals. At the present level and pace of contraceptive use, it will take the program some 20 years to produce a visible effect on the fertility rate. By that time, the Ghanaian population will be more than 30 million. The Greater Accra Region will be reaching a population density of at least 1,400 people per square kilometer. The country will be hard pressed to create the necessary social and economic environment to satisfy the needs of a population more than twice the size of the current population.

3. The project has experienced some stagnation, requiring new strategies to increase CPR to meet follow-on project targets. To reach the growth rate goal of 1.75 percent (which had been set for the year 2000), even in the next decade, adjustments in strategy are necessary to reduce the plateauing effect observed in program performance and to prevent a long period of stagnation which could be fatal at this early stage of program development.

4. There has been a great deal of expansion in provision of services, but not enough productivity. The growing demand for services such as delivery, prenatal and postnatal care, immunizations, nutrition, etc., must be met. In these conditions, family planning is the new arrival competing with other MCH services for MOH resources. After three years of this project, the results are poor at the clinic level.

The family planning experience in almost all countries shows that the integrated approach is not successful in reaching adequate levels of contraceptive prevalence. Without questioning the intentions of the GOG to expand health services to all the areas of the country, even the most remote and inaccessible ones, the family planning program has to develop new strategies to become cost effective and produce the results that the government wants to obtain.

It would be best to concentrate efforts on making the clinics that are already in the MOH system work effectively and efficiently to serve family planning clients before expanding the system further. The MOH's current system of 584 clinics providing family planning is already over-extended. This is manifested by the fact that each of these clinics is serving, on average, less than one woman per day per clinic.

A feasible, cost-effective approach would be to establish a few well-located, high-caseload, sole-purpose family planning clinics providing all contraceptive methods. These exclusive family planning clinics would have well-trained and motivated personnel, and would operate in adequate facilities with the aim and the capacity of producing up to 75 CYPs per day. These levels could be attained through making VSC readily available on an easy-access, outpatient basis, assuring full supply of other longer-acting contraceptives (Norplant, IUD, and injectables), and making the provision of oral contraceptives essentially an over-the-counter process. The approach could be implemented in one clinic in each regional capital city starting with four regions. At the same time, the action of the clinics would be supplemented with concentrated efforts of the social marketing or a community-based distribution program, or both. It is estimated that together these actions would produce an additional 10 percent prevalence in those four regions. This would amount to an additional 5 percent for the entire country. (See Annex G for a more detailed explanation of this approach.)

5. The method mix needs to change towards more permanent and semi-permanent methods to meet the GOG population policy goal and the follow-on project targets. While the MOH program appears to have a more balanced approach, the GSMP sells a substantial quantity of less-effective methods. If the MOH TBA outreach activity and the PPAG community-based distribution (CBD) program continue as presently being implemented, they will also only increase the use of

condoms and vaginal tablets (see Section 7.4). The low participation of permanent and semi-permanent methods, like surgical contraception and IUDs, makes the program weak in its ability to obtain high prevalence rates, and also reduces the chances of having a significant impact on fertility.

2.8 Recommendations²

1. During the implementation of the follow-on project, one sole-purpose, high-caseload family planning clinic offering all contraceptive methods should be established in the regional capital city of the four regions showing the most promise for growth in contraceptive prevalence: Greater Accra Region, Eastern Region, Brong-Ahafo Region, and Ashanti region.

2. Efforts should be made to create the necessary conditions for the GSMP to intensify the distribution of contraceptives in the four regions mentioned above.

3. The oral contraceptive pill should be declassified and made available to field workers such as CBD workers and TBAs and other alternative outlets for purchase mentioned in the social marketing section of this report (Section 4). The MOH and private organizations should be encouraged to accelerate the positive trend toward the use of more effective methods, including oral contraceptives and especially the IUD and VSC.

²Recommendations are listed consecutively throughout the report.

3. Logistics and Management Information System

3. Logistics and Management Information System

3.1 Project Objectives

The project paper called for ". . . a management supply system to be in place in the public sector permitting the MOH to maintain a full supply of contraceptives at central, regional, and district warehouse and service outlets. This system will provide timely service statistics and commodity flow reports to project managers who will use them for management decisions and for feedback to all implementing levels. Additionally . . . an effective management supply system to strengthen and expand the contraceptive retail supply network will have been developed."

3.2 Midterm Evaluation Findings and Recommendations

The midterm evaluation noted considerable improvement in the supply management system, but also called attention to several problems, especially those related to contraceptive logistics. The evaluation recommended continuing technical assistance to the MOH to improve the contraceptive supplies system, and recommended improvements in the procurement system and early removal of contraceptives from the port of Tema (customs) warehouses.

3.3 Logistics System

3.3.1 MOH

The contraceptive logistics system at the MOH is outlined in Annex H. At the district level, the same nurse in the MCH/FP program is in charge of providing contraceptive services to users and keeping and supplying contraceptives to the lower levels or to users. The regional and national nursing officers have to request contraceptives from the MOH pharmaceutical stores, which keep contraceptives as well as other drugs and clinic supplies. The MCH nurses are not always aware of contraceptive availability or of expiration dates, since physical inventory is not taken periodically at central and regional warehouses.

Delays in receiving and clearing contraceptives from customs at the port in Tema is a serious problem. Consignments take up to 24 months from the date of shipment to their receipt at the central MOH warehouse. Shipments for GSMP managed by DANAFCO were reported in a 1990 audit (Parnell Kerr Forster) to clear customs and reach DANAFCO's Accra warehouse within one week.

Associated with the delays in clearing customs is the lack of communication from the shipping agency, Matrix International Logistics, Inc. This has made it impossible to trace shipments en route, and has resulted in document losses complicating difficulties in obtaining customs clearance. A lack of understanding between the MOH and the Ministry of Finance and Economic Planning has also complicated getting contraceptives out of customs.

Due to these delays, by the time the contraceptives reach the MOH stores, their shelf-life has been reduced considerably. In some instances, the central warehouse has received consignments six or

fewer months before expiration. At the time of this evaluation, the following expired contraceptives were waiting to be destroyed at the Tema warehouse:

<u>Contraceptive</u>	<u>Amount</u>	<u>Expiration Date</u>
Lo-Femenal	54,000 cycles	June 1991
Conceptrol	887,300 units	July 1991
Ovrette	303,600 Cycles	September 1991
Sultan	1,002,000 units	October 1991

This is equal to 49,000 CYPs or six months supply for MOH distribution. These contraceptives are occupying space needed to store a shipment of condoms recently arrived in Ghana being kept in a separate warehouse. There are also expired contraceptives at the regional and district levels awaiting destruction.

Stock-outs have also been observed in Depo Provera (not supplied by A.I.D.), Lo-Femenal, and IUDs during the implementation of the project. There is a current stock-out of Conceptrol throughout the system, and there is currently no stock of either Depo Provera or Cu-T 380 at the central MOH warehouse.

Contraceptives do not flow downward to nourish the system as they should. Rather, lower levels of distribution have to move upward to collect them, depending on the charity of the other programs for use of a vehicle or the availability of public transport. Supplies are meant to be picked up from the stores at the immediately higher level by the lower level using whatever means of transportation is available. The districts often have more difficulty in collecting supplies; usually they are far from the regional store and have fewer resources than the region. The evaluation team had the opportunity of seeing one of the districts collecting supplies from the regional stores using a taxi cab.

The contraceptives are well kept at the central and regional warehouses, although some improvements are needed (see Annex G). In contrast, contraceptives are kept in poor conditions at the clinics and at district storage facilities. In the districts, they are piled up against the wall in rooms with little or no ventilation, receive direct sunlight, and are sometimes mixed with other drugs and clinic supplies. In the clinics, storage space often consists of one cabinet which is inadequate to store all the supplies for the clinic including contraceptives.

3.3.2 GSMP

The logistics system used at DANAFCO to manage GSMP products is a simple one. The depots have a minimum stock of one month. When this level is reached they place a requisition by telephone to the central office and the contraceptives are made available to them from the central warehouse within one week. Each of the four DANAFCO wholly owned depots was supplied by the project with a van to resupply the retail chain of its region; outlets not visited by the van come to the depot to get GSMP products. (See Section 4 for a fuller discussion of the GSMP logistics system.)

3.4 Management Information System (MIS)

3.4.1 MOH

The MOH MIS has received technical assistance from some A.I.D. intermediaries, primarily the Family Planning Logistics Management project (FPLM) project and the Centers for Disease Control (CDC). FPLM and CDC trip reports indicate the system has improved considerably during the past few years. The midterm evaluation noted that the system had improved but was still weak. This is also the perception of the personnel interviewed during this evaluation. The major contributions of the technical assistance have been the design and field trials of a new form to collect information at the four levels of the project and training of personnel. Three workshops were held to train 75 nurses at the regional and district levels with FPLM and CDC participation. Since then, these nurses have trained personnel in the 584 MOH clinics that are currently providing family planning services.

Quarterly and monthly reports flow quite smoothly through the system. Monthly reports come from the clinics to the district, where a consolidated report is made quarterly to be sent to the region. A second consolidation is made at this level before the national consolidation is made in Accra, also on a quarterly basis. The reports are completed with small delays at the clinic level, but are submitted in a timely manner at the other levels. Clinics usually omit the monthly report when the activity in family planning has been nil for that particular month. Supplies are provided upon receipt of the reports and commensurate cash from sales of contraceptives — an asset of the system in terms of helping to make the MIS work.

The form used to report to upper levels is simple, although it still takes significant time at the clinic level to complete. There is one form to report UNFPA product movement and another, similar one for A.I.D. products. The report contains useful information, and people in charge of reporting at different levels know the concepts involved, although new acceptors, continuing users, and total users are still interpreted differently in the clinics. Based on the monthly and quarterly reports, the nurses estimate the quantity of contraceptives needed and order from higher levels or provide the supplies to the lower levels.

Workshops are held quarterly at regional and district levels and bi-annually at the national level to discuss problems encountered in the MIS and program performance. These have served as well as a learning tool and as a channel for feedback.

Despite all the improvements gained to this point in the MIS, completing the reporting form is still a time-consuming activity, particularly at the clinic level. The many compilations are compromising accuracy, and during each consolidation some important information is lost. The central office does not know the situation at the district and clinic levels. The regions are not aware of what is happening in the clinics of their catchment area.

There is little use made of the data in planning and analysis at the MCH/FP program central office. Except for the workshops mentioned above, feedback that can help the nurses in their managerial activities of the program is almost non-existent.

3.4.2 GSMP

The GSMP project at DANAFCO has a simple and efficient MIS. Invoices are sent to the Accra office monthly along with matching bank deposits and a sales report by contraceptive method. Few

errors are made with this system; in any event, errors would be easy to correct in any event, since the original documents do not undergo any processing in the field and they are readily available to make corrections, if needed.

DANAFCO does little analysis of the information, except at the central office, where some global analysis for the country is done to estimate future sales. Detailed analysis by retail outlet in order to identify high- and low-volume accounts, to track business by new and repeat accounts, or to track growing and waning accounts is not undertaken. Feedback is also lacking in the system.

3.5 Conclusions

1. Contraceptive stock-outs are a source of frustration for family planning activities. The serious problems still present at the international and local levels need to be solved by A.I.D./Washington, USAID, and the GOG. Contraceptives have been introduced into the country about to expire, and then they, as well as other shipments, have remained in port longer than they should. The result has been that they do not serve the purpose of protecting the women and men in fertile age against pregnancy; instead, significant quantities have had to be destroyed.

2. Transport of contraceptives is another problem. The vehicles available to the MOH are too busy with other activities to cope with the distribution needs of the family planning project.

3. The storage facilities are inadequate in clinics and districts. Inventory controls and commodity storage practices are below the required standards.

4. It is now universal practice for the clinics to produce monthly reports, but the many compilations are compromising the accuracy of the data and missing valuable information for management purposes at each level of aggregation.

5. At some point in the future, it would be worth considering the development of a computerized system that would reduce the work of staff, improve accuracy, and maintain disaggregated information for analysis. The appropriate time for this would be when the current MIS and the logistics system are fully in operation, and when there is a guarantee that automation in family planning would be used to serve family planning activities as its primary goal.

3.6 R: commendations

4. USAID should ask the follow-on project providers of technical assistance for MIS and logistics to review project paper assumptions and to make contraceptive projections reflecting the history and distribution capacity of the program.

5. A.I.D./Washington and USAID must assure that no contraceptives expired or about to expire will be sent to the program, and the program must dispose of expired contraceptives as soon as possible, following the USAID regulations for A.I.D.-donated contraceptives.

6. With A.I.D./Washington assistance, USAID should monitor contraceptive requests at all stages of the process (manufacture, shipment, arrival at European port, transshipment, arrival in Ghana) and should keep the GOG informed of shipment status.

7. **A.I.D./Washington should ensure that every shipment is made with the necessary documents to clear the contraceptives through customs in the shortest time possible.**

8. **A.I.D./Washington should respond to the mission's requests for quarterly statements of the contraceptives account.**

9. **USAID and the MOH, together, should solve the problem of contraceptives in port. If no clear-cut solution is found, USAID should look for alternative solutions, for example, contracting with the private sector to clear shipments and deliver them from the port to the MOH central warehouse.**

10. **Future technical assistance for the MIS and logistics systems should concentrate in assisting the GOG to provide additional training in sound warehousing and storage practices, and to train appropriate personnel to analyze and use service statistics at all levels and in both sectors (GSMP and MOH).**

11. **At least three vehicles should be devoted to family planning only. These vehicles should be used for supervision and supplying contraceptives to the most densely populated regions and districts in the MCH/FP program. USAID should consider providing them through the follow-on project.**

12. **Continuing users and total users should be deleted from the MIS reporting form. Further, one single report that can be sent to both donors, USAID and UNFPA, should be created and implemented.**

4. Social Marketing of Contraceptive Products

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4. Social Marketing of Contraceptive Products

4.1 Project Objectives

DANAFCO was awarded the contract for the GSMP component of the project. The project paper lists five objectives that bear directly or indirectly on GSMP efforts. Briefly, these objectives include creating a) a largely self-financing and reliable distribution system for family planning products throughout the established retail network b) with phased expansion, and c) training consonant with normal private sector practices using d) advertising and marketing to increase consumer awareness of contraceptive products and e) contributing to a target 16 percent prevalence among married women in fertile age (MWIFA) by 1988. (See Annex I for a full list of relevant objectives.)

4.2 Midterm Evaluation Findings and Recommendations

The 1988 midterm evaluation of the GSMP component found that, to varying degrees, DANAFCO had fulfilled all of its responsibilities as set forth in the contract. Achievements highlighted in the midterm evaluation included program management and marketing plan development with technical assistance from the Social Marketing for Change (SOMARC) project, creation of at least one point of distribution in all 10 regions, and an increase in personnel assigned to the project.

The midterm evaluation raised some concerns regarding DANAFCO's ability to fulfill project objectives, focusing on lack of experience in the types of marketing skills required by the project and the lack of a systematic means of project coordination with other interested parties such as the Ministry of Finance and Economic Planning, USAID, and MOH (for specifics, see Annex J).

Midterm evaluation recommendations concentrated on increasing the marketing and management skills of GSMP personnel through a strong program of technical assistance and training and creation of a GSMP advisory council to provide guidance, coordination, and project support. The recommendations also suggested less direct involvement by USAID in project management in order to stimulate greater Ghanaian leadership. (See Annex J.)

4.3 Advisory Council

An advisory council was established in 1986 under DANAFCO's contract with the Ministry of Finance and Economic Planning. The council's primary work was to approve advertising before submission to the Pharmacy Board. The council comprised representatives from the Pharmacy Board, the MOH (including the deputy director of Medical Services and the head of the MCH/FP Division), the Ghana Broadcasting Corporation, the Ghanaian National Family Planning Program, the Ministry of Information, the National Council of Women and Development, the *Daily Graphic* newspaper, and Lintas (a local advertising firm). Initially, the advisory council met quarterly, but more recently it has met less regularly at intervals from six months to nearly a year, specifically to review advertising materials.

4.4 Management

DANAFCO's management responsibilities are specified in its contract with the Ministry of Finance and Economic Planning as follows:

- to prepare and execute a marketing plan including advertising and promotion;
- to provide total management of the marketing program;
- to prepare and distribute required financial and commodity reports to the Ministry of Finance and Economic Planning and USAID;
- to conduct periodic retail audits to ensure adequate inventories, storage, and display; and
- to provide sales data for estimating CYP.

4.4.1 Management Structure

The project is currently managed within the DANAFCO organizational structure by a full-time program coordinator, who is responsible for all aspects of GSMP. The program coordinator is supervised by the general manager-administrator, who devotes half his time to the project. The general manager-administrator reports to the company's managing director. Thus, the third level of authority within DANAFCO management is the highest and only level of full-time project management.

The program coordinator is supported by an advertising manager who devotes time to the project as needed. It is understood that he was hired in response to the midterm evaluation's recommendation to provide more direction to DANAFCO's advertising sub-contractor. This individual's expertise, however, is technical and not strategic, limiting his ability to improve the strategic input to advertising support for the project. At the time of the midterm evaluation, a full-time research director was also employed by the project under a one-year sub-contract with SOMARC. The sub-contract was not renewed and the position was terminated.

4.4.2 Marketing Plan and Project Documentation

Substantial progress has been made in project planning and documentation. In 1990, the program coordinator updated the marketing plan. The plan details project accomplishments and includes project plans for new product introductions, pricing, sales targets, promotion, distribution, sales, training, and the possible marketing of IUDs and anti-malarials. It is a fairly comprehensive document and has been a useful tool for the program coordinator. The program coordinator also prepared three other documents: a summary action plan for 1991/1992, including revised sales targets for 1991; a proposed schedule of project implementation through the end of the second project extension; and *A New Approach to Marketing of Contraceptives and Oral Rehydration Salts in Ghana (March 1986-May 1991)*, detailing project accomplishments from inception through May 1991.

In 1989 the GSMP received the "Marketing Program of the Year Award," presented by the Institute of Marketing Ghana.

4.4.3 Management Difficulties

Interagency coordination and communication have not become more systematized since the midterm evaluation, with the net effect that DANAFCO has not been able to provide the kind of overall project management hoped for in the midterm evaluation.

One reason for this result may have been the midterm evaluation's recommendation that USAID back away from day-to-day involvement in project management. Although this approach is essential to enable DANAFCO to assume full responsibility for project management, the extent to which DANAFCO personnel may have needed guidance and technical support in a management decision-making transition period may have been underestimated. Also, the extent to which DANAFCO would devote top-level management time to the project may have been seriously overestimated. According to DANAFCO, GSMP represents approximately 1.5 percent of its total business. Within the private sector, it would be an unsound business decision to allocate significant top-level management time to such a small, out-of-the-mainstream product line.

Another difficulty was that the program coordinator, while the highest level full-time manager of the GSMP effort, did not actually have sufficient decision-making power regarding program implementation and budget allocations. Consequently, the GSMP was something of an "orphan" within the management structure, unable to care for itself and not sufficiently supported by those with authority.

A related problem has been the temporary nature of the project due to an initial extension of the contract with SOMARC for two years and a second extension of one year since the end of the first extension date of September 1989. During this time, DANAFCO had two short-term contracts with SOMARC, and a period with no contract at all from September 1989 through May 1990. Such a situation makes it difficult for a management team to maintain a firm commitment to long-range plan development.

Some significant difficulties have been encountered in the area of financial management and supervision, notably in the negotiation of remuneration of sub-contractors. A major difficulty has been the lack of specific measurement criteria against which approval for payment for services rendered is agreed to by both parties prior to initiation of work. Currently, SOMARC has direct contracts with DANAFCO, and the two primary sub-contractors, Lintas (for advertising and promotion) and MSRI (for market research). This potential area of conflict is thus resolved, at least in the short term. Having the Ghanaian sub-contractors all contracting directly with a U.S.-based firm, however, is not ideal in terms of creating and maintaining a Ghanaian focus and initiative for project success. SOMARC also entered into a direct sub-contract with Multiprint, a packaging house in Abidjan, Ivory Coast, to create packaging for the new Secure (Norquest) oral contraceptive which is replacing Norminest. A second key effect of these direct sub-contracts with SOMARC is that they remove the possibility of coordinated management responsibility for the project from DANAFCO.

4.4.4 Adequacy of Technical Assistance Received

The midterm evaluation recommended that the project should supply DANAFCO with training to improve its ability to take on a greater level of responsibility for overall project management. The following activities represent a serious effort to comply with this recommendation.

- In 1988 the GSMP program coordinator was sent to Boston, Massachusetts, for a six-week training program in marketing management conducted by International Marketing Institute at Boston College.

- In 1989 Management Development and Productivity Institute, Accra, was awarded a fixed contract by SOMARC to provide training for senior-, middle-, and field-level management personnel at DANAFCO. The training needs of the personnel were researched in advance. A two-day course on strategic planning, pricing, and marketing was prepared for senior management; a three-day course adding development and supervision of sales people and development of action plans was implemented for middle management; and two one-day courses were implemented for field management, including an introduction to marketing, sales planning and forecasting, controlling channels of distribution, and merchandising and sales promotion.

- In 1989, both the GSMP program coordinator and the general manager of pharmaceuticals were sent to Lome, Togo, along with four members of the Lintas staff, six of the MSRI staff, one from the Afromedia staff (a Lintas subsidiary), and two from the University of Ghana, for a SOMARC Marketing Research Module.

- In late 1990 the managing director of Pharmahealth Centre, Ltd., responsible for training chemical sellers, was sent to a SOMARC Forum training program in Harare, Zimbabwe.

- One member of SOMARC staff has made six trips to Ghana since 1989, and other SOMARC staff have also provided technical assistance with some regularity.

4.5 Distribution

The primary distribution goals for GSMP were to provide distribution to 22 sub-depots³ in 10 regional capitals and to extend distribution, on an experimental basis, through expansion of retail outlets to include chemical sellers, registered midwives, traditional birth attendants, and other potential market outlets such as market women and factory clinics or the military.

As stated in Section 3.3.2, distribution from the port through packaging at the DANAFCO central warehouse in Accra to the four wholly owned DANAFCO depots works well. The training of close to 3,000 chemical sellers, which allowed them to become distribution points for condoms, vaginal foaming tablets (VFT), and oral contraceptives, has been a major achievement in the planned phased expansion of the distribution network.

4.5.1 Performance of Various Distribution Points

DANAFCO provides distribution to the 10 regional capitals, and has warehouses which store DANAFCO and GSMP products exclusively in six of the 10 regions. There are 13 active sub-depots, and an additional four in an experimental stage of evaluation. Over the life of the project, DANAFCO has opened up 3,328 outlets for GSMP products in which training has first been provided:

³A sub-depot is an independent wholesale and/or retailer. This is usually a pharmacy or chemist shop which may or may not be served by a DANAFCO distribution vehicle.

Table 9

GSMP Products Retail Outlets

Type of Outlet	Number
Pharmacists	323
Chemical Sellers	2,839
Market Women	131*
Filling stations, bars, supermarkets	35*
Total	3,328

Source: Based upon data provided by GSMP.

* Allowed to distribute barrier method only, per GOG regulations

It should be noted that DANAFCO does not sell less than bulk packaging of products at DANAFCO depots and requires cash sales except from long-standing and substantial accounts. Consequently, small sub-depots, retailers, and the very low-volume outlets for community-based distribution, are excluded from both the product delivery pipeline and from wholesale prices. Although these small distributors pay less than the retail price for their supplies, the demand for cash in advance and a low mark-up (see below) discourage them from distributing more contraceptives.

DANAFCO provides product to NGOs, such as PPAG, and the MOH when they have out-of-stock situations. Some effort has been made to gain access for GSMP products to the G.B. Olivant distribution network of 240 distribution points for general household goods. Also, an experiment with hairdressers as distribution points is to be undertaken before March 1992.

The DANAFCO distribution network includes four DANAFCO wholly owned depots, two DANAFCO agents⁴ who are compensated on a 2.5 percent commission basis, and approximately 20 sub-depots which distribute a variety of manufacturers' products, in addition to DANAFCO and GSMP products. All but one of these sub-depots are also paid a commission on GSMP products at the 2.5 percent rate. (For a full list of type and number of agents, by region, see Annex L). Sales data from DANAFCO suggest that the bulk of distribution is accounted for by the four DANAFCO depots, and that the agents and sub-depots are relatively minor players in extending the distribution network.

There may be two key contributing factors to this situation. First, the DANAFCO wholly owned depots are the only distributors in the system to have been provided with vans to make GSMP deliveries to retailers. This means that many retailers are not served by the vans, and must come to DANAFCO agents and sub-depots to obtain stock. Further, it means that sales data reported for

⁴An agent uses a warehouse not owned by DANAFCO to store DANAFCO products and distributes these products in his own vehicles. He distributes only DANAFCO and GSMP products.

Table 10

**Regional Sales Distribution
by DANAFCO Distributor Status**

Distribution Point	% of Population*	% of GSMP Sales**		
		Panther	Kamal	Norminest
Wholly owned Depots	48.0	84	83	84
Agents	24.0	8	11	12
Sub-Depots	29.5	2	1	1

Source: Based upon data provided by GSMP.

* Percent of total population present in regions where each distribution type is the primary regional point of distribution.

** An additional 3 percent of sales for Kamal and Norminest are broken out separately in DANAFCO sales reporting for sub-depots not located in regional capitals; hence, percentages do not add up to 100 percent. For full table, see Annex L.

the four regions having vans may be significantly distorted because they include a) sales from vans that actually take place in other regions and b) resale to "agents"⁵ who buy at DANAFCO depots for resale elsewhere. Second, 2.5 percent is an extremely low margin, providing little incentive to retailers to make the effort either to travel to obtain product (especially if they have no vehicles themselves) or to move product off the shelf if they adhere to suggested retail prices. New DANAFCO price increases reflect significantly improved margins to retailers, somewhere in the 20 to 30 percent range, which is considerably closer to their margins on other products sold. Although the price increases to the retail trade had gone into effect some two weeks before this evaluation took place, retailers had not been told they would receive a margin increase.

The report of the Parnell Kerr Forster financial analysis of DANAFCO operation written in February 1990, recommended that GSMP vans be restricted to exclusive GSMP product delivery. For this recommendation to be executed in any meaningful way, however, one salesman would have to be detailed full time to each GSMP vehicle, and it appears no such provision was made.

4.5.2 Product Availability

Informal checks on stock, prices, sources, point-of-sale materials and retailer training were made during field trips to pharmacies, chemical sellers, and DANAFCO sub-depots. GSMP product was consistently visible either on shelves behind the counters, or in counter display window areas, or both.

It should also be noted that product other than GSMP specific brands was available in all outlets visited: NeoSampooon most notably in 10 of 12; Lo-Femenal in 5; Mycrogynon (or Eugynon or Neogynon) in 5; Delfen vaginal foam in 4; and Sampooon condoms in 1 or 2. Although DANAFCO

⁵These "agents" appear to be individual entrepreneurs who have their own vehicles and have seen an opportunity to start a "moonlight" distribution business, purchasing product for resale from pharmacies, clinics, PPAG, and DANAFCO.

was most often mentioned as the source of GSMP products, PPAG and MOH were mentioned at least once each as resources for GSMP products, and agents or pharmacies were also mentioned as sources for Panther, NeoSampoo, ORS, and Mycrogynon.

There is a proliferation of donor products supplied to MOH and PPAG in the retail outlets of the GSMP chain. One reason specifically mentioned by retailers near PPAG clinics was consumer loyalty; the PPAG has been around far longer than the GSMP project and women are loyal to the PPAG brand oral contraceptive. Other reasons for product proliferation may include the possibility that a) higher retail margins or better credit terms can be had with them than with GSMP products, and b) the clinics in which they can be purchased may be easier for some retailers to get to than DANAFCO wholesale outlets.

4.6 Management Information Systems

At the DANAFCO Kumasi depot, as at DANAFCO's other three depots, each cash sale is invoiced at the time of transaction. Credit accounts are invoiced at time of payment and bank deposit. Invoices must tally with bank receipts when they are sent to headquarters in Accra weekly. Also, each sale is recorded in a product inventory book at the depot, and product-on-hand records are changed accordingly, so that out-of-stock situations can be anticipated and avoided if possible. Similar sales data are required of agents and sub-depots in regional capitals, but it does not appear such data are required of sub-depots in general. They buy product on a cash basis and their commissions are recorded at headquarters. It appears that in some cases these commissions accumulate on the books for as much as a year, at which time the retailer may opt to be paid in cash or in product.

Although this system provides the necessary data at headquarters to project stocking needs and return-to-project funds⁶ and other necessary financial information, the data are accumulated at headquarters by region only. Distribution analyses are not performed by type of wholesaler or by type of retailer. Sales continue to fluctuate from quarter to quarter, whereas more careful analysis of sales by outlet, by month and/or by type of retailer and by location for resale, could lead to a more systematic approach to supply, obviating avoidable out-of-stock situations. Also, the accounting procedures currently being used may significantly distort the actual sales of product by region, making it difficult to project CYP or prevalence data by region with any confidence.

No analysis has been conducted to evaluate sales performance in relation to promotional and mass media efforts to gain some understanding of how effective these efforts have been in generating incremental sales.

The GSMP program coordinator prepares first-rate financial and commodity position reports for USAID and the Ministry of Finance and Economic Planning on a quarterly basis.

⁶These are composed of a small portion of the profits from the sales of commodities for investment in a program fund.

4.7 GSMP Sales Data

4.7.1 Sales Volume

The 1990 marketing plan for the GSMP lists as project objectives increasing contraceptive prevalence in urban areas from 7 percent to 10 percent, and increasing unit sales volume by 50 percent. DANAFCO sales contributed 3 percentage points to the estimated contraceptive prevalence rate of approximately 8 percent achieved in 1990. Year-end 1990 GSMP sales data for the Greater Accra Region translate to an estimated 11.3 percent prevalence among MWIFA. Since these data are regional and not solely urban, it is hypothesized that this target has been exceeded in urban Accra. Total unit sales volume increases from calendar year 1988 (the first full year of product sales of all three GSMP family planning product brands) to 1990 equals a growth of 29 percent, considerably short of the somewhat optimistic objective of 50 percent:

Table 11

Total GSMP Unit Sales 1988 and 1990

Total GSMP unit sales, 1990, all brands	5,621,133
Total GSMP unit sales in 1988, all brands	4,355,361
Difference: 29 percent growth	1,265,772

Source: Based upon data provided by GSMP.

4.7.2 Market Share

Market share data are heavily relied on in the private sector to evaluate the effectiveness of distribution, advertising, and promotional efforts in gaining consumer loyalty in a competitive market. The 1990 market share figures indicate that the GSMP condom brand clearly dominates the condom market. Kamal, the GSMP VFT, also holds a substantial lead in its market. Norminest, which has received no mass media advertising support since spring 1989, and which is being phased out of the market, was at parity with MOH brands of oral contraceptives. (See Annex K.)

Table 12

1990 Unit Sales

Sector	Condoms	VFTs	Orals
GSMP	80%	66%	42%
MOH	18%	28%	41%
PPAG	2%	6%	17%

Source: Based upon data taken from 1991 compilations for year-end total sales, 1990, for GSMP, MOH, and PPAG.

4.7.3 Product Prices

Prices are reported as being higher, generally, at the DANAFCO sub-depot level and when agents and pharmacies are used than when a DANAFCO depot is used. Retailers also reported buying directly from a PPAG or MOH clinic. Products distributed by the MOH and PPAG are readily and consistently available through the DANAFCO retail chain. Table 13 shows wholesale and retail price ranges quoted by retailers.

Retailers reported that family planning products constitute only a small part of an outlet's business/profit, and that ORS sales often equal or exceed family planning products in total sales.

Table 13

Wholesale and Retail Price Ranges

Product	Wholesale cedis	Retail cedis
Condoms (unit)		
Panther	10 - 18	10 - 20
Sampooon	N.A.	N.A.
Orals (cycle)		
Norminest	40 - 50	50 - 80
Mycrogynon	50 - N.A.	60 - 100
Eugynon	N.A.	60 - 100
Lo-Femenal	42 - 65	60 - 100
VFTs (8 pack)		
Kamal	44 - 100	50 - 150
NeoSampooon	80 - 250	150 - 300 per tube/20
ORS	40 - 70	50 - 100

Source: Based upon data provided by retailers.

Note: By comparison, a bar of soap costs 500 cedis, an egg costs 50 cedis, a loaf of bread costs 200 cedis, and one Embassy cigarette costs 20 cedis.

Since February 1989, there have been four price increases in each product in the GSMP line. The impact on wholesale and retail prices of the first three of these increases and return-to-project funds are detailed in the table in Annex L. The most recent price increase, effective October 1991, raised the prices of the Panther condom and the Kamal foaming tablet. Because it is being replaced by Secure (Norquest), Norminest was not increased. Secure was launched along with the new Kamal packaging in October 1991. Also, DANAFCO has entered into a new price agreement (which reflects the latest DANAFCO price increase) directly with SOMARC which is as follows:

Table 14
New Price Agreement

Price/Margin	Panther 1 unit	Kamal 8 pack	Secure 1 cycle	Protector* 3 pack
Cost to distributor**	10 cedis	60 cedis	60 cedis	76 cedis
DANAFCO margin 25%	2.5	15	15	19
Price at wholesale	12.5	75	75	95
Wholesale margin**	1.5	8	8	20
Retail price	14	83	83	105
Retail margin**	6	22	22	30
Suggested retail price	20	105	105	135
Anticipated wholesale and suggested retail margins at these prices are:	Panther	Kamal	Secure	Protector
Wholesale margin	10.7%	9.6%	9.6%	13.3%
Retailer margin	30%	20.9%	20.9%	22.2%

Source: Based upon data provided by GSMP.

* The Protector condom is about to be introduced as an upscale product (see Section 4.8). Panther condom distribution will continue.

** The 1990 Marketing Plan proposes an annual price increase across the board of 30 percent to adjust for inflation, 1990-1994.

Price increases have apparently been motivated by a) increases in costs of production and delivery (there was a major increase in fuel prices last year), b) inflation, c) increasing margins and return-to-project funds, and d) the market's apparent ability to absorb higher prices without significant reductions in consumer sales.

4.7.4 Population Groups Reached

The 1990 GSMP User Intercept Study, in which consumers were intercepted after having been observed purchasing a GSMP product at a pharmacy or chemical seller, offers profiles of actual purchasers. These profiles conform with the consumer group profiles targeted for each brand: basically lower and middle class Ghanaians in the fertile age range. The research was conducted in four urban areas, Accra, Kumasi, Takoradi, and Tema, so the profile cannot be projected to rural GSMP product consumers. In addition, no comparative data exists with which to determine whether there is any distinction between these consumers and those served by either the MOH or PPAG. (See Annex L.)

4.8 Product Packaging

Norminest was introduced in 3-cycle packs in 1988, as recommended by the midterm evaluation, with one instruction sheet in English with visuals per pack. Single cycles from the 3-cycle packs continued to be sold, however, so it is not known what proportion of consumers have actually received the instructions.

Secure (Norquest) was introduced in October 1991 in single-cycle packaging with instructions, again in English with visuals. The package is attractive. No expiration date is visible. Also, no Secure brand identification is visible on the Norquest cycle itself; this may cause consumer confusion. Secure is targeted as an upscale brand of oral contraceptive. When Norminest sells out, this means there will be no low-end oral contraceptive in the product line. On the other hand, Secure prices at this time are not significantly different from MOH and PPAG oral contraceptives, so it should be no less affordable to lower socio-economic groups than these products.

Kamal was reintroduced at the end of October 1991, in a new, improved pack of eight individually foil-wrapped tablets with instructions in English with visuals.

A new product, the Protector brand condom, which is to be introduced in a three-unit pack, is targeted to an upscale male market. The target launch of Protector was initially scheduled for March 1991; 1,198,800 units have been received at DANAFCO's central warehouse and are awaiting packaging. The launch is now tentatively scheduled for the end of January 1992.

Panther is still distributed in 100-unit bulk packs overlaid with the Panther logo, and sold in single units displaying the Panther logo. It was planned for Panther to be reintroduced in 1990 in three-packs, but it was eventually decided Panther would remain in single units as part of the strategy to distinguish it from the more upscale positioning of the Protector condom.

Norminest packaging included the generic Ghana family planning logo, but the logo was not included in either the new Kamal or Secure packaging. In an attempt to reduce packaging costs, it was argued that the trade-off of logo inclusion versus the cost of three-color printing would not be cost-effective. The question is whether this logo, which is the same as that worn by MCH/FP health workers, creates any sense of consumer confidence which might be a purchase motivating factor.

4.9 Advertising

4.9.1 Mass Media Campaigns

A full six-month run of 30-second radio introductory endorsement advertising for Panther, Kamal, and Norminest was carried out between May and November 1989. Approximately six spots ran each day, and the intensity varied from two to six days a week.

The only mass media campaign carried out in 1990 was an eight-week run on radio during April and May promoting the Panther-Kamal Sweepstakes. In this campaign the two brands and the specific distribution outlets of pharmacies, chemical sellers, and registered midwives were mentioned, but no information motivating purchase other than the acquisition of a sweepstakes entry form was included.

DANAFCO's contract with SOMARC ended in September 1990. On October 19, 1990, DANAFCO requested in writing that 5 million cedis be made available from the Ministry of Finance and Economic Planning return-to-project funds to pay for radio promotions for Panther and Kamal and promotional materials for all three GSMP brands (i.e., Panther, Kamal, and Norminest). Approval was not received for release of the funds until February 1991.

In 1991 the original introductory radio 30-second commercials for Panther and Kamal were rerun for four weeks in May only because there was no budget provided for second-generation, more motivational advertising production.

As this chronology shows, from November 1989 until the initiation of the new advertising campaign launched at the end of October 1991 (implemented under a direct sub-contract between SOMARC and Lintas), no mass media advertising was undertaken for Norminest, because it was scheduled to be taken off the market when Secure was to be introduced (originally scheduled for spring 1990).

Further, Panther and Kamal were advertised for a total of only 12 weeks in 1990 and 1991, hardly enough to have any meaningful impact on sales activity. Indeed, Panther sales for the year 1990 show only a 3 percent increase over 1988 sales (see Annex L).

During this same period, Kamal sales increased 160 percent — not surprising since 1987 was Kamal's introductory year. Norminest sales increased by 26 percent, also not surprising since Norminest was introduced in the third quarter of 1987.⁷ The impact seen in sales reflects initial product sell-in to the trade and not advertising effectiveness.

4.9.2 Other Promotional Activities

The mass media campaigns throughout this period were supported primarily by point-of-sale metal sheets and posters. Some special promotions were undertaken, including the production of a small number of T-shirts to be worn by ball boys at soccer matches, and by men and women in tugs-of-war, or by men in draughts (checkers) competitions. Also, booths were manned at University Hall Days to approach the student population, and activities were undertaken in support of relevant trade associations such as the Chemical Sellers Association and the Society of General Medical Practitioners. Some print media advertising was carried out but the reach of these media is not precisely known. Outdoor advertising (billboards) was carried out in 1989-1990. Its reach and impact are not completely known.

4.9.3 Brand Awareness Data

The only brand awareness data that exists to give some measure of the impact of advertising and promotional activities are drawn from a comparison of the study data of two male-only samples: the 1988 Tracking Survey conducted by GSMP in Accra, Korforidua, and Kumasi, and reported by SOMARC; and the 1991 Pan-African Protector Advertising Baseline Study conducted in Accra, Kumasi, and Takoradi (published October 1991 by MSRI). The data are encouraging regarding the success of the advertising campaign in generating brand-specific awareness:

⁷Figures derived from calendar year sales figures supplied to the evaluation team, November 1991.

Table 15

Brand-Specific Awareness

Brand Awareness	1988 tracking (N = 907)	1991 P-A (N = 400)
Panther	49.6%	82.5%
Sultan	46.4%	57.8%
Other condom brands	6.7%	69.8%*

Source: Based upon data reported by SOMARC and MSRI.

* Percentage reflects multiple responses.

Clearly, the Panther advertising had an impact on brand awareness. Equally clearly, there is a significant increase over this three-year period in reported awareness of other condom brands and also an increase in awareness of Sultan. This information suggests that part of the sluggish sales of Panther may be the result of the proliferation of "competitive" products in the retail outlets where Panther is sold.

4.10 Market Research

Significant gains have been made in planning and implementing market research that is responsive to the informational needs of GSMP. A total of seven informative, well-documented studies have been implemented by MSRI with technical assistance from SOMARC during 1990 and 1991 (see Annex L).

4.11 Training of Pharmacists and Chemical Sellers

The training of pharmacists and chemical sellers was instrumental in gaining some 3,000 outlets for distribution for Norminest, in particular, which had not been permitted to be sold through these outlets prior to the training. Pharmacists and chemical sellers interviewed all spoke favorably of the training they had received from Pharmahealth Center Ltd., a pharmaceutical firm with expertise in training. In addition, quite a few kept the training manual they had received close at hand.

At the same time, the May 1990 GSMP User Intercept Study points out that ". . . most Norminest users are not consulting doctors either before going on the pill or undertaking a check-up afterwards. A good number of users also did not know what to do if they skipped or failed to take a pill, and many were not knowledgeable about who should take a pill (contraindications) or what the method's . . . side effects were."⁸ Since this report also indicates that pharmacists, chemical sellers, and doctors are "the frontline sources of product information," it may be that women are not asking questions.

⁸MSRI, May, 1990, Draft Final Report, page 9.

It may also be that junior-level employees (who have not been trained) of these outlets are often the actual salespeople contacted by customers.

4.12 Sustainability Projections

To date, the effort required to project the figures necessary to determine the circumstances under which self-sustainability might be approachable has not been undertaken. The figures required include sales volume, product mix, price parameters and sustenance levels of advertising, promotion, distribution, and management support of a theoretically mature business.

4.13 Conclusions

1. DANAFCO has done a fine job preparing and disseminating the required financial and commodity documents. It has also made solid progress in the development and use of marketing plans, and provides sales data quarterly for estimating CYP.
2. DANAFCO's ability to provide total management of the marketing program still leaves much to be desired. Three factors have been significant contributors to this problem: a) the temporary nature of project extensions and the hiatus in management contracts, b) insufficient understanding of the levels of financial and managerial support needed for an "orphan" business division, and c) the continuing lack of experience and authority vested in full-time project management.
3. Considerable effort has been devoted to responding to the midterm evaluation recommendations to create an advisory council and to provide technical assistance and training to improve GSMP management's understanding and use of marketing and management skills. Reality dictates, however, that it takes years of experience to provide the kind of total project management needed and expected; i.e., marketing experts capable of understanding and using, with full sophisticated authority, market data and market development tools and approaches and resources.
4. Significant progress has been made in expanding the number of retail outlets with the potential for distribution of condoms, VFTs, and oral contraceptives through the pharmaceutical network (pharmacists, chemical sellers) since project inception. Efforts to expand the distribution outlet types beyond the pharmaceutical chain have been slow, however, and small in terms of impact. The emphasis has been primarily on very small outlets — market women, filling stations — rather than on some alternatives which represent far larger and far more rapid possibilities for extending program outreach, such as the military or clinics in large factories such as the Ashanti Gold Mines.
5. DANAFCO's ability to provide the wide distribution network anticipated for GSMP products has been severely limited by the lack of provision for salesmen dedicated solely to such service.
6. The lack of a dedicated sales force has also resulted in those retail outlets that have a demand for contraceptive products resupplying themselves wherever possible, including MOH and PPAG clinics, other retailers, and "agents."

7. One result of this multi-channel approach to resupply has been a proliferation in the private sector of all brands of contraceptive products available through donor programs. In terms of creating a social marketing program that offers a wide choice of methods to the ultimate consumer at convenient locations for purchase, this turn of events is to be welcomed. In addition, this proliferation of "competitive" products in the marketplace could serve to keep retail prices low in an environment pressing for price increases to meet project objectives of self-sustainability. At the same time, given all the data in this report on CYPs, unit sales, and market share of GSMP, MOH, and PPAG, the outputs anticipated in the follow-on project appear significantly out of line with what the distribution system can be reasonably expected to deliver. The follow-on project paper projects commodities needs for the MOH and GSMP as follows:

	<u>MOH</u>	<u>GSMP</u>
Condoms	13,800,000	39,000,000
Orals	3,000,000	39,000,000
VFTs	5,200,000	76,000,000
IUDs	50,000	5,000
Norplant	1,000	—

These output figures do not correlate with the detailed cost estimates for commodity provision outlined in another section of the same project paper, which correlate much more closely with the reality of distribution in-country at this time.

8. Significant advances have been made in creating an environment accepting of family planning specific-brand advertising (including oral contraceptives). This situation can be used to advantage to inform consumers about the reasons for selecting a particular method and brand, as well proper use and contraindications. Awareness must be converted into use if population growth rates objectives of the GOG are to be met.

9. Some key market research questions critical to any well-informed evaluation of the overall effectiveness of GSMP have not yet been addressed. One is a retail audit to evaluate effectiveness of the distribution system in urban and rural areas of each region and to understand the nature and extent of price points of a variety of "competitive" family planning products widely available in retail outlets. Another is a quantitative pricing study to determine impact of various price strategies on both market share and project self-sustainability. A third is some kind of quantitative consumer knowledge, attitudes, and practice (KAP) study which could generate some hard data on source of supply and geographic dispersion of users, etc., along with prevalence of specific reasons for non-use among non-users and benefits derived from use among users.

10. Information critical to understanding how the retail trade is performing by geographic area and outlet type is still not being accumulated and analyzed in a way that would increase management responsiveness to market conditions, even though this information exists and is used for financial analysis.

11. Self-sustainability is a responsible long-term objective for the private sector social marketing aspect of any national family planning initiative. To achieve such a goal, however, requires setting carefully analyzed and documented parameters for conditions to be achieved in government policy and regulations in order for there to be a significant impact on the possibility of business development. Setting those parameters requires commitment to measurable accomplishments

convertible to business development impact on the part of donor agencies, host governments and implicated ministries as well as primary contractors and private sector social marketing units.

4.14 Recommendations

13. The follow-on project recommends the creation of a social marketing unit. The unit should be dedicated exclusively to distribution and marketing of family planning products until the business is mature, stable, and the contribution to the prevalence target has been met. It is equally important that this unit should be a Ghanaian firm.

14. The social marketing unit must be managed by top-level Ghanaians with sufficient experience to manage a mature distribution and marketing business. Management must be supported, as required by the follow-on project, by technical assistance from resident expatriates having expertise in social marketing and business development strategies, including MIS. This expertise is critical in developing a self-sustaining business, but should have been substantially imparted to Ghanaian management by the time the business has met its goals for maturity.

15. The social marketing unit should be structured so that all funds, equipment, vehicles, and personnel are dedicated solely to its primary business: marketing and creating a reliable and effective distribution network for family planning products. Where there are existing distribution chains such as DANAFCO and G.B. Olivant, they should be used if they are appropriate and cost-effective. A monopoly of distribution by one chain, however, would be counter-productive to the long-term potential for the two primary project goals of availability and sustainability.

16. Two options for organizing such a unit should be given particular attention: a) it could be a wholly owned and autonomously managed subsidiary of an existing Ghanaian firm, or 2) it could be an independent organization with the long-term business objective of becoming a wholesaler and retailer (primary marketer) of a variety of family health products after its family planning business objectives have been met.

17. The primary contractor for the follow-on project must review the commodity needs projections as soon as possible after arrival in Ghana to ensure that commodity provisions are in line with projectable sales expectations for MOH and GSMP, given the levels of advertising and IEC support expected to be fulfilled at that time.

18. Clinics in the private sector which serve substantial populations are an obvious and as yet unexploited possibility for extension of GSMP products and even DANAFCO products. These large population-base possibilities should be given a higher priority in the follow-on project.

19. A detailed business plan including commitments to funding and measurable levels of performance against objectives must be written and executed.

20. Because commitment to use of modern family planning products in Ghana is so low, a second-generation campaign should make every effort to convert concept awareness into brand awareness, and brand awareness into use. Brand awareness does not convert to use unless people understand the connection between a brand name and some personal benefit to be derived from use which they find meaningful.

21. The possibility of private stock ownership of the social marketing unit — by its parent if a wholly owned subsidiary or by private investors if independent — should be given serious consideration, at least on an experimental basis. Investment by private sector Ghanaian nationals — individuals or corporations in related businesses and even by the GOG — would address the critical business development factor of shared commitment through shared risk. Such investment would also generate working capital, and perhaps foster cooperation through commitment.

22. Benchmark quantitative market research studies must be undertaken (and repeated in five years to measure impact and adjust strategy) to develop a coherent strategy of distribution goals and motivational advertising weight and content. These studies are necessary to provide the entire social marketing effort — private and public sectors alike — with quantitative data on the urban and rural retail environments as well as with quantitative data on contraceptive prevalence, and consumer knowledge, attitudes, and practices regarding family planning methods and brands. A CPS or repeat DHS could respond to some of these questions. No family planning program can be comprehensively managed in a culturally sensitive and highly targeted way without such critical data.

23. An MIS must be implemented in the social marketing unit which includes reliable statistics on retail outlet movement by retail outlet type and geographic location, so that trends in business development or loss can be monitored and strategic responses can be implemented.

24. A pricing study should be implemented to determine what the proper prices should be for products targeted at lower, middle, and upper socio-economic groups.

25. The potential impact of the proliferation of donor contraceptive products in the private sector distribution chain must be examined seriously in order to develop a coherent and responsive strategy. Questions of impact to be addressed are a) responsiveness to consumer needs for choice and convenience and b) ability to set and assess prevalence contribution targets for the GSMP, MOH, and NGO project components.

26. A distribution strategy must be created which concentrates on efficient and reliable delivery to the most densely populated and accessible areas of Ghana first and then to less accessible and less densely populated areas.

27. Consideration should be given to creating a distribution cost equalization fund within return-to-project funds to offset the incremental cost of distribution to less accessible population groups.

5. Public Sector IEC Activities

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5. Public Sector IEC Activities

The Ministry of Health developed a four-pronged approach toward what can be characterized as "social marketing of the concept of family planning." Activities in this approach were aimed toward a) current and potential family planning couples, b) health care providers, c) the general public, and d) policy makers.

This section on public sector IEC activities deals with the IEC campaigns directed largely toward the general public (as opposed to the private sector product-specific IEC activities that were discussed in Section 4). Section 6 discusses the substantial training program to improve the attitudes of health care providers toward family planning as well as to increase their skills in service delivery and communication. Section 7 discusses quality of care as it affects the attractiveness of the services to potential family planning clients. Section 8 discusses the Population Impact Project's role in creating a more positive environment for population among policy makers.

5.1 Project Objectives

The original project paper of February 1985 contained the following IEC goals:

- inform potential clients of the availability of family planning services;
- recruit and maintain new clients;
- provide accurate information to new and existing clients and combat rumors and misconceptions on family planning methods; and
- educate males about the important family health benefits of child spacing methods.

The project logframe did not contain any mention of IEC targets such as specified increased levels of awareness and knowledge. The first specific IEC targets appear in a series of buy-ins to the Population Communication Services (PCS) project. These mission-funded buy-ins totaled \$1,800,960 as of the time of this evaluation. In addition, PCS also used central funds. Targets included the following:

- train 4,000 MOH service providers in family planning counseling;
- print 1,500,000 copies of method-specific booklets;
- print 10,000 copies of a quarterly newsletter for MOH and NGO personnel;
- train approximately 250 GRMA midwives in outreach skills;

The following three targets were part of a pilot IEC campaign launched in 1989 in three regions — Ashanti, Brong Ahafo, and Central:

- help increase awareness and knowledge of family planning from an estimated 68 percent to 90 percent;

- help increase the contraceptive prevalence rate from 6 to 14 percent nationwide; and
- increase current acceptor levels in MOH and NGO facilities by 30 percent.

Additional IEC targets were established in October 1990:

- carry out planning sessions in 42 districts for the IEC campaign;
- produce advertisements for 180 billboards and 21,000 posters;
- produce one live drama, one Ghana Broadcasting Corporation television standard program length video, family planning calendars, and 300 audio cassettes;
- reprint 300,000 family planning leaflets, 1,500 wall charts, and three editions of 10,000 copies of each newsletter;
- produce one television program and a weekly radio soap opera for nine months; and
- produce 200 additional signs identifying MOH clinics where family planning services are available.

Also included in the buy-in scopes of work was the objective to carry out specific studies before mass media campaigns were undertaken to determine message strategy and the knowledge, attitude, and practices of specific target groups, such as men. In addition, all family planning IEC training under the project was to be evaluated over time to determine if it had changed attitudes and improved performance, especially among service providers.

By the time of the midterm evaluation, USAID had decided to go beyond original project design and develop a nationwide IEC program targeted toward decision makers, service providers, potential or current contraceptive users, and the general public. Specific IEC objectives differed by target group:

a) The goal of the decision makers target was to regenerate top leadership interest and involvement in population program planning.

b) The goals of the service provider target were curriculum development, training in motivation, counseling, and contraceptive use, and development of IEC teaching materials for use by service providers.

c) The goals of the potential and current user target were development of motivational posters, brochures, and family planning signs to be used primarily in health clinics, along with instruction inserts for GSMP oral contraceptives.

d) The goals of the general public target included a folk media project to reach out to rural areas, a male health education campaign, and outreach to journalists and the public through press releases in the print media.

5.2 Midterm Evaluation Findings and Recommendations

The midterm evaluation concluded that significant progress had been made in all areas of IEC materials and strategy development, but raised the following concerns: a) MCH health education staff would need continued financial support from the MOH to continue IEC activities and staff training and to obtain necessary equipment and transport; b) Continued effort would need to be placed on engaging decision makers in the family planning initiative required to meet GOG population growth rate objectives; c) MOH Health Education Division staff would need to be expanded if additional campaigns in the areas of AIDS, oral rehydration therapy, Expanded Program on Immunization (EPI), and nutrition education were added to its workload; and d) the MOH would have to maintain high-quality service and a reliable supply of contraceptive products at clinics to meet the demand created by the motivational campaign.

The midterm evaluation recommended a) that the project continue to provide technical and financial support to build MOH IEC capabilities and to expand institutional development activities, and b) that the MOH encourage and the project provide support for further development of a strategy to build high-level commitment to family planning.

5.3 Performance against Targets

5.3.1 Training, Planning, and Production of IEC Materials

- Training was given to 5,154 Level B service providers in family planning counseling (see Section 6.4.9).
- Considerable planning activity was undertaken in the three regions selected for the IEC campaign launch (Ashanti, Brong-Ahafo, and Central), and planning sessions were carried out in all 42 districts targeted.
- 200,000 leaflets on condom, oral contraceptive, and VFT use were distributed late in 1988, along with 20,000 copies of *A Guide to Family Planning and Modern Contraceptives*.
- 16 issues of the quarterly newsletter, *Health Today*, were printed and disseminated in quantities of 10,000 per issue.
- 90 billboards and a large number of posters were produced. The sites for billboards were reduced to 60 in July 1991 because of the expense involved, and it was believed that the budget would be better allocated to radio broadcast dissemination. A total of 8 thematic posters were created. The number of posters ultimately produced is not clear; however, posters represent the single biggest budget item in both phases of the IEC campaign. It is known that the posters were disseminated to all or nearly all MOH MCH clinics, and research results indicate that the majority of women and men interviewed who remembered having seen a poster had seen it at a clinic. Posters were also widely in evidence at the sites visited.
- 2 live dramas, *Last Pregnancy* and *Resolution*, were videotaped. Only *Last Pregnancy* was performed live, once at each of the three regional IEC launches. The two were shown in video houses in the three regions and were shown to small groups using Health Education Division video equipment. Also, both were transferred to 16mm film to be shown at community presentations

followed by discussion and question-and-answer sessions. They are shown as often as nurses can manage and as budgets allow. Efforts have been targeted toward larger communities first, gradually reaching out to less-populous areas. *Resolution* was distributed to all 10 regions.

- The video, "Our Concern," was produced by the Union of Radio and Television Networks of Africa, and has been broadcast on television twice.
- "Health Update," an interview format radio show, is broadcast at 8:45 a.m. on Wednesday mornings and rebroadcast on Saturdays at 3:45 p.m. Sixty 15-minute weekly episodes of this show have been aired. Family planning is included at least once a quarter.
- "Family Affair," a 15-minute soap opera, began broadcasting in June 1990, on Sunday mornings at 6:30 a.m. in English and at 8:45 in Akan (the predominant language in the campaign regions), and on Mondays at 5:45 p.m. in Akan. Topics covered in 1990 included clean surroundings, causes and treatment of diarrhea, health of pregnant mothers, breastfeeding, weaning foods, immunizations, and child welfare clinics. The principal characters are a man and his two wives, one who lives with her father, a doctor, and one who has stayed in the village. The former is enlightened and always talking about family planning and hygiene. She has only one child; the village wife has five. The series was originally scheduled for nine months, but because it has been very popular and has received an award, it has been extended without contract.
- "Family Doctor," a Ghana Broadcasting Corporation (GBC) production is broadcast in Akan and is similar in format to "Health Update." Translations of "Health Update" materials are aired free on this program. In addition, the Health Education Division can request adult education panel time, which is free public service announcement time. It is reported that this time is granted as often as the Health Education Division requests it. The only limitation is the Health Education Division's ability to create programming, given its other commitments.
- A male motivational campaign was launched in July 1991, and is scheduled to run until March 1992. Three radio spots were produced (two 75-second spots; one 30-second spot). These are broadcast five days a week, alternating between one and two airings per day. This is aired on GBC-1 in Akan, and repeated with the same frequency on GBC-2 in English.
- 600 audio cassettes with the family planning jingle, interspersed with announcements about family planning and popular Ghanaian music were produced and distributed to mini-buses (*trotros*), buses, taxis, and drinking bars having cassette-playing equipment. The jingle was picked up on national radio.
- Signs were produced identifying MOH clinics where family planning services are available. Originally, 58 districts of Ghana received these signs; then the number of districts was increased to 110. There is money in the budget for signs for all the new districts. The signs are being phased into operation slowly, however, since personnel are not available to install them.
- 50,000 plastic shopping bags decorated with family planning slogans and logos were produced for dissemination at campaign events.
- A well-designed flip chart on human reproduction was produced for dissemination to health workers in all regions. PPAG also received a limited supply of this valuable resource.

Thus, although the precise specifications in terms of materials production have not been met in all cases, it can be said that a substantial effort to disseminate awareness generators and information has been made.

5.3.2 Efforts to Engage Decision Makers in Family Planning

The Population Impact Project (discussed in Section 8) was successful in engaging decision makers in the national family planning effort and in generating an environment favorable to the dissemination of family planning products and information to approach the GOG population target. The town meeting (*durbar*) and pre-launch activities in the districts also had a favorable impact on involving local decision makers and opinion leaders such as chiefs, queen mothers, and linguists.

5.4 Research Studies

The MOH Health Education Division, with technical assistance from the PCS project, designed and executed an extensive series of qualitative and quantitative research studies of IEC efforts. These were conducted quarterly in the six regions having regional health education officers, beginning among women in July 1988. The six regions included three targeted for the IEC campaign discussed in Section 5.5, and three which would be designated as non-campaign (or control) regions following the campaign launch in March of 1990.

Briefly, the design of this research included identifying 25 "sentinel" sites within a 15-kilometer radius of an MOH MCH clinic. Twenty-five one-on-one interviews with women and five focus group interviews with six to eight women were conducted at each site each quarter. The total sample for the "household interviews" was roughly 625. Data from the quantitative sample was hand-tabulated, and given, along with a report on the focus group results, to the local nurse who would pass it along to the regional health education officer. The focus group data was never reported in total at the national level. A sub-sample of the group results was reported at the national level, however.

Each wave of quantitative data up to and including round seven, conducted in August 1990, was reported in a different manner. This effectively rendered much of the data meaningless without retabulation, which has not been done. Further, in round seven, the campaign areas were broken out from the non-campaign areas, and it is clear that care was not taken in ensuring a matched sample. Not only are these data not comparable to any of the previous data, but their value as a campaign evaluation tool is undermined by lack of comparability between campaign and non-campaign populations interviewed.

The initial wave of research for the male motivation campaign was also carried out in August 1990 and has the same inherent problems in terms of providing reliable data as the female sample. This is also the final wave of interviews to be completed in this series, as the series has been discontinued.

The follow-on project places heavy emphasis on both qualitative and quantitative research to pretest and evaluate all MOH IEC and GSMP motivational efforts. Based on the research experience to date, it is clear that careful attention must be given to research methodology, particularly when the research is to be used to assess project impact.

5.5 IEC Campaign

As mentioned in Section 5.1, a pilot IEC campaign was launched in Ashanti, Brong Ahafo, and Central Regions in 1989, with the following objectives:

- help increase awareness and knowledge of family planning from an estimated 68 percent to 90 percent;
- help increase the contraceptive prevalence rate from 6 to 14 percent nationwide; and
- increase current acceptor levels in MOH and NGO facilities by 30 percent.

The research design implemented to evaluate performance against these three objectives in campaign versus non-campaign regions indicates that the campaign appears to have largely met the first of its specific targets in the campaign regions. Data on the non-campaign regions, however, will not be reviewed for two reasons: a) the mismatching of the samples in the PCS research rendered the data of questionable utility, and b) all the literature, brochures and posters were distributed to MOH MCH clinics throughout the country, so that effectiveness measurements in campaign and non-campaign areas would have little value even if the samples were matched.

5.5.1 Increased Awareness of Family Planning

Table 16 on the next page indicates that of those interviewed in the campaign regions in August 1990, 96 percent of women and 75 percent of men were spontaneously aware of at least one modern method of family planning. The information in the table also underscores the need for the male motivational campaign launched in 1991, in the sense that men clearly are not as well informed as women.

Table 16

Awareness of Modern Family Planning Methods

Method Awareness	Campaign Regions*	
	Women (%)	Men (%)
Aware of any modern method	96	75
Aware of 3 or more modern methods	90	42
Condom	89	59
Pill	86	48
Injection	86	29
Female Sterilization	80	11
Foaming Tablets	78	47
IUD	65	11
Male Sterilization	31	7
Diaphragm	25	6

Source: Based on data provided by the MOH Health Education Division.

* All fractions from .1 - .4 are rounded down; .5 - .9 are rounded up.

5.5.2 Increased Contraceptive Prevalence

The second objective of the campaign was to help increase the contraceptive prevalence rate from 6 to 13 percent nationwide. The CYPs in campaign regions did increase dramatically during the training and sensitization pre-launch activities; however, they declined after the actual beginning of the campaign. It could be that stock-outs caused the decline or that small retailers stocked up during pre-launch periods. In any event, the impact on national prevalence is not relevant since the campaign was launched in three regions only.

5.5.3 Increased Acceptor Levels

The third campaign target was to increase current acceptor levels in MOH and NGO facilities by 30 percent. The household interview format does not permit evaluation against this facility-based criterion because questions regarding acceptance are not asked by source. It has been pointed out elsewhere that the average MOH clinic provides less than one CYP per day (see Section 2.5.2).

The following table summarizes, in round percentages, the proportion of men and women in the campaign region sample interviewed in August 1990, who said they had seen or heard campaign materials. The impact of these materials in terms of generating acceptance is unmeasurable, however, because the location of awareness generation was not recorded. For example, although poster messages consistently received high levels of recall, the majority of people who said they had seen posters saw them in clinics, in which case the posters cannot be considered to have motivated the people to come to the clinic. In terms of the other elements of the campaign, the three mass media efforts, billboards and music cassettes ranked at the top of the list, along with the family planning emblem, which may have been seen on signs outside clinics, on posters or billboards, or on the uniforms of health workers.

5.5.4 Effectiveness of IEC Campaign Materials

Radio was not used in the first phase of the IEC campaign because of the experimental nature of the campaign. All data collected in studies over the past few years, however, indicate that at least half of all Ghanaians have a radio at home. In phase two, the IEC campaign is using radio to disseminate messages to dispel rumors and to engage men in the family planning decision-making process.

Billboards also did well. Whereas it was often reported that the particular poster promoting the image of family planning service providers was so attractive that people actually removed them from their public display areas to take them home, billboards would probably not encounter this difficulty, and may be far more efficient.

Although the *durbars*, video shows, and dramas did not have as much recognition as the mass media elements, they are effective outreach campaign elements bringing family planning to people in rural areas. A first-rate family planning role-playing event was seen in a village outside Kumasi. The local TBA was presented to the crowd as a resource for them in their own community, and the people engaged with great interest in an open discussion and question-and-answer period. Similar role-playing events are undertaken by health clinic workers in their outreach community work, and they report this type of presentation is well received by village people. These outreach efforts, however, are often hindered by a lack of vehicles and teaching aids such as booklets, brochures, and flip charts.

Table 17

Awareness of Campaign Materials

Material Awareness	Women (%)	Men (%)
Saw billboard	64	67
Heard FP Theme song	63	74
Saw emblem	61	71
Ever heard radio program	59	N/A
Seen an FP brochure	48	50
Heard playlets	45	47
Heard FP durbar	24	34
Recall FP drama, past 6 mos.	22	24
Saw poster in community(est)	30*	43*
Saw poster in clinic	80	61

Source: Based on data provided by the MOH Health Education Division.

* This is approximate for all posters together. The question was asked for each poster separately, so this percentage is an average aggregation.

The multi-method booklet produced for the campaign is very good. The booklet was targeted toward health care professionals and provides both written and graphic descriptions of each method available through the MOH.

PPAG is using the MOH Health Education Division flip charts to advantage in some of its clinics, but only has a few of them. The flip chart is an excellent education tool and was consistently described as very useful by MOH field workers.

The following table breaks out budgets in terms of the percent of budget allocated to campaign elements. Although posters are often helpful in generating top-of-mind awareness and in creating a more or less positive environment, they do not impart any substantive information. The emphasis they received in the budget seems out of line with their ability to convert awareness into committed family planning. By contrast the billboards, jingle cassettes, and radio programming outperformed the posters and cost significantly less.

Table 18

Percent of Budget Allocated to Campaign

Item	Phase I	Phase II
Posters	52	67
Special events	18	7
Materials pretest	N/A	10
Radio production	9	16
Video concert production	7	N/A
Emblem badges	3	N/A

Source: Based on data provided by the MOH Health Education Division.

5.6 Conclusions

1. Ensuring that top-level GOG decision makers are included in the evolving Ghana family planning efforts being funded by A.I.D. is clearly something that must be addressed by both the U.S. Embassy and USAID mission through person-to-person technical and political dialogue.
2. The strong motivational work being carried out by outreach efforts to village communities cannot be expected to translate into contraceptive prevalence unless the services required are also available and well publicized in a positive environment. This can be achieved through strengthening community-based distribution.
3. The leaflets, booklets, and flip charts produced have been widely distributed and have been well received by both MOH health clinic workers and NGOs, but both groups need more of them. Outreach efforts undertaken by health clinic workers at the village level are often hindered by the lack of these teaching aids as well as vehicles.
4. The data generated by the PCS household interviews and focus groups are largely unusable and unused. More than enough data already exists within the PCS raw data and other research data available on constraints against and motivations for family planning, however, to form the basis of a strategic mass media motivational campaign. This campaign would be designed to overcome constraints and to help individual men and women make responsible family planning decisions.
5. Posters received an inordinate emphasis in IEC campaign budgeting, given that they were primarily used as top-of-mind awareness generators within health clinics. Those who have decided to explore family planning alternatives for themselves and their families need informational assistance, such as the brochures and booklets and video shows and radio informational programming.

6. National radio is now being used to combat rumors and encourage male participation in family planning decision making, and to promote responsible decision making by men and women through the soap opera, "Family Affair." These are excellent tools for disseminating carefully prepared, well-researched, and culturally sensitive family planning informational and educational messages.

7. Substantial emphasis is placed on both qualitative and quantitative research to pretest and evaluate all MOH IEC and GSMP motivational efforts in the follow-on project. Although this kind of research is critically important, it needs to be kept in mind that unrealistic demands for multiple complex research initiatives can squander the project's human and financial resources.

5.7 Recommendations

28. Full emphasis should be placed on creating a comprehensive strategic plan for mass media dissemination of motivational information designed specifically to convert the high levels of awareness of the concept of family planning and methods into informed commitment to the practice of family planning. The emphasis should be placed on motivating people to come to points of service and product delivery, and not on those who have already arrived at those points. Short informational campaigns constrained by budgetary shortfalls are not acceptable. The campaign must legitimize family planning practices and must make family planning practice relevant to the individual in terms of personal benefits to be derived from family planning.

29. In the follow-on project, the mass media radio campaign should dominate national IEC campaigns, with secondary emphasis placed on the regional grassroots activities such as *durbars* and concert parties. The latter are excellent programs, along with the role-plays implemented by clinic outreach personnel, but they reach an extremely limited audience by comparison with the radio audience.

30. A.I.D. should reallocate resources to ensure full funding of IEC motivational radio campaigns (as well as GSMP campaigns) for the full five years of the follow-on project. MOH funds allocated for this purpose in the follow-on project should be redirected to the sole purpose of developing and maintaining on air the "Family Affair" radio soap opera, which also promotes equally the MOH's six primary health initiatives: malaria, EPI, MCH, family planning, nutrition, and diarrhea. Characters representing public sector health workers at the community and family planning clinic levels should be included in scripts. This approach will further enhance the self-image of public sector health workers, as well as their image in the minds of policy decision makers and the people of Ghana who will come to them for information and services.

31. The budgetary commitment to posters should be considerably reduced, while the budget should be increased for radio; reproduction of informational leaflets, brochures, and flip charts or other teaching aids; billboards; and vehicular and resource support for role-plays and video presentations on family planning.

32. The follow-on budget should provide funds for whatever levels of duplication of the multi-method booklet are necessary. If the specific flyers for each method have been evaluated and found to be helpful to potential clients, they too should be abundantly available for clinic clients to take home — clearly visible on walls or counters at all clinics. Also, method-specific flyers should be made available in local languages, minimally in Akan.

33. Consideration should be given in the follow-on project to providing all the IEC materials — flip charts, booklets, flyers — to NGOs engaged in the family planning initiative in Ghana.

34. The male motivational campaign should be evaluated and adjusted as necessary at the end of its current air schedule (March 1992). The project should give priority to ensuring there is a well-targeted male motivational campaign in the follow-on project. Men in Ghana are key decision makers influencing child-bearing decisions and must be drawn into the effort to plan children responsibly. The data in this report clearly indicate that men have not achieved the same levels of awareness of the range of family planning options available in Ghana as women. An environment must be created through the IEC campaign in which men and women are encouraged to discuss family planning together.

35. Project market research needs should be reviewed by a technical assistance specialist in market research for the purpose of designing a minimal research plan to cover the needs of the program for both development and evaluation purposes.

36. The follow-on project calls for major mass media campaigns for both GSMP and IEC efforts, yet does not provide a meaningful budget for advertising, and places financial responsibility for all IEC mass media development and dissemination on MOH funding. If this activity is to be supported from the non-project assistance funds of the follow-on project, special attention should be given to budgeting and making available adequate funds for this essential element of the program. There should be separate budgets for GSMP motivational advertising and Health Education Division IEC motivational public education spots and programming. These are complementary programs, to be sure, and must be well coordinated, but their purposes are entirely different and each one needs to be given full support for the role it plays in converting awareness to commitment to family planning.

**6. Training of Public Sector Health Care Providers
and Private Sector Midwives**

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6. Training of Public Sector Health Care Providers and Private Sector Midwives

6.1 Training Targets

The original project paper of February 1985 contained the following training targets:

- MOH personnel in 306 clinics and in all community health programs;
- 20 central and regional management personnel in six-week courses;
- 564 clinic personnel in five-week, one-half day courses;
- 846 outreach personnel and 2,115 community volunteers in one-week courses;
- 50 gynecologists in reproductive health and 75 nurse/midwives in order to integrate family planning into the curricula, review and revision by the Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO) of the MCH/FP curricula in medical, nursing, and midwifery schools;
- 3 MOH central and regional officers in the United States in a master's program in public health; and
- 50 persons abroad through study tours.

None of the subsequent amendments to the project agreement or the 12 project implementation letters contained additional or revised targets for training. Additional targets for each discrete training activity were, however, contained in a series of project implementation orders/technical (PIO/T) that were issued for JHPIEGO, American College of Nurse/Midwives, and PCS work in Ghana.

6.2 Midterm Evaluation Findings and Recommendations

The midterm evaluation noted that an MCH/FP pre-service curriculum for nurses and midwives had been developed and that much in-service technical and management training for MOH personnel had been completed. Issues raised by the evaluation team included, among others, insufficient facilities for clinical practice, a need for in-service follow-up and trainee evaluation, and a need for ongoing service monitoring and supervision. With regard to training, the evaluation's major recommendation was that the MOH, with technical assistance from the project, should arrange an evaluation of all training participants that would identify strengths and weaknesses in knowledge and skills and allow for measurement of the impact of training.

6.3 Difficulties in Determining Achievements

It was difficult to obtain precise quantitative and qualitative information on the achievements of the project's training component for several reasons. First, the MOH has adopted a policy of decentralization which means that data on the number of trained personnel are kept at the district level. This is compounded by there being no one at the central level who is assigned full-time responsibility for coordinating family planning activities. Second, the information available at USAID is incomplete and in some cases dated. Third, A.I.D. Cooperating Agencies, particularly JHPIEGO, do not provide timely and complete information to USAID and the MOH even though their grant agreements specify that quarterly reports are to be submitted to USAID within two weeks of the close of each quarter. These reports are to include a detailed statement of all accomplishments during the quarter and a summary of accomplishments to date.

As a consequence of these difficulties, the following discussion is based on the incomplete statistics that were available and on oral information obtained at the central level and during field trips to the interior of the country.

6.4 Training Abroad

Both this project and other centrally funded projects provided training for at least 39 doctors (mostly MOH) and 129 (again, mostly MOH) nurse/midwives from the beginning of the project through March 1989. Information on those trained between March 1989 and December 1991 was not readily available at the time of the evaluation. The Contraceptive Supplies Project has provided \$192,156 for long- and short-term training during the life of the project. Training has taken place in the United States and in countries such as Nigeria, Kenya, Egypt, and Mauritius. Courses have included both skills training and training of trainers (TOT) training and have dealt with public health, reproductive health, family planning, IUD and VSC training, natural family planning, program management, IEC, social marketing, child survival, and safe motherhood, etc.

Many of the training participants have come from the interior of the country and have usually worked at a regional or district facility. Trainees interviewed indicated that this training was indispensable, particularly for the nurse/midwives and the doctors involved in VSC services. The result of this training has been the institutionalization of Ghanaian capability to carry out in-country training programs in MCH/FP.

6.5 In-Country Training

With respect to in-country training, there have been several large-scale training programs for TBAs, both MOH and private sector nurse/midwives, and MOH clinic personnel. Table 19 lists all in-country training under the project (other than that of the GSMP) for which data were available.

6.5.1 Traditional Birth Attendants

In April 1989, the Contraceptive Supplies Project provided \$671,140 to the American College of Nurse Midwives (ACNM) to implement a project to train 8 master tutors, 60 trainers of TBAs, and 3,000 TBAs in five of Ghana's 10 regions. The training for the TBAs consisted of a short course of about three days, spread over six to 12 weeks, and covered prenatal, obstetric, postnatal care, and

Table 19

Summary Chart: In-Country Training

Type	Number
Traditional Birth Attendants	2,949
Private Sector Midwives	238
MOH Midwives	435
Faculty and Nurse Educators	58
Private Practitioners in Accra	NA
FP for General Practitioners	120
Voluntary Surgical Contraception	82
MOH Clinic Personnel	5,177
MOH Logistics Personnel	689
Total	9,748

Source: Based upon data provided by the MOH MCH/FP program.

family planning. The TBAs were not trained in the use of oral contraceptives because the MOH has officially opposed using TBAs as providers of oral contraceptives. Upon graduation, the TBAs were given a kit containing midwifery and primary health care items, including condoms and foaming tablets. No system has been established, however, to provide the TBAs a consistent supply of contraceptives at prices lower than clinic prices. Table 20 shows the TBA training that has been accomplished.

An operations research study carried out by Columbia University evaluated the ACNM TBA training program and presented the final report in June 1990. Focus group discussions with TBAs and health post workers before and after training suggested that they had a more positive attitude toward family planning after the training. Their primary health care and family planning activity level, however, was found to be quite low and few community members sought them out for these services. In the Dangbe District of Accra, current use of modern methods had increased from 3.5 percent to 6.7 percent two years later, but this was not necessarily as a result of TBA efforts.

One of the strengths of the TBA project is the strategy to train future supervisors as trainers of the TBAs. During a visit to Sunyani, it was learned that 36 out of 40 TBAs had received a supervisory visit during the prior month.

Table 20
TBA Training

Region	Master Tutors	Level B Supervisors/Trainers	TBAs
Volta	14	59	561
Northern	10	64	620
Upper West	10	62	600
Brong Ahafo	15	61	600
Central	14	61	568
Total	63	307	2,949

Source: Based upon data provided by the MOH MCH/FP program.

6.5.2 Private Sector Midwives

A grant was signed in July 1987 with ACNM to assist the Ghana Registered Midwives Association to increase access to family planning services and information through private sector midwives. Targets were to train 100-150 midwives in family planning and basic business skills, to carry out 100 visits to the trained midwives, to have 100 private maternity homes providing family planning services, and to reach 172,050 persons with information on family planning.

By June 1990, 238 midwives had been trained, 241 visits had been completed, and 168 private maternity homes were providing family planning services. Forty-seven of the midwives had been trained in IUD insertion.

An operations research study on this project carried out by Columbia University, published in June 1990, provides two important statistics: a) of the women interviewed 79.6 percent were using family planning for the first time, which indicates that the midwives were reaching a previously unreached group; and b) the average midwife in the project was serving six new acceptors and three continuing users per month. This finding coincides with information obtained in interviews with private midwives during the course of this evaluation.

Under the follow-on project, consideration could be given to assisting private sector midwives to start their own maternity homes. This would cost approximately \$3,000 per midwife. As shown above, midwives currently in the program are serving about 100 women per year, and this is just the start of the program — the clientele-building phase for family planning. In year one, the cost per user would be \$30; pro-rated over a five-year period it would result in a cost per user of \$6, even if the caseload were not to increase above 100 users. Grant funding would not be essential except to establish an initial revolving fund. Any such enterprise would, of course, need to be experimented with on a small scale to assess its impact on family planning.

6.5.3 MOH Nurse/Midwives Project

With \$72,097 of central A.I.D. funds, JHPIEGO began to support the pre-service training of nurse/midwives in May 1987 through the Schools of Midwifery and Nursing in Accra, Kumasi, and Tamale. The first year's target was to train 96 nurse/midwives. A year later, with a \$109,479 buy-in from the Contraceptive Supplies Project, the following additional targets were set: to train 120 nurse/midwives in family planning and IUD insertion, to provide 120 IUD kits, and to implement a new family planning curriculum in the Schools of Midwifery and Nursing. In April 1989, a second buy-in for \$622,960 was processed which included continued training for another 120 nurse/midwives. Table 21 indicates the number of nurse/midwives trained by region:

Table 21

Nurse/Midwife Training

Region	1987-88	1988-89	1989-90	1990-91	Total
Greater Accra	16	19	22	15	72
Ashanti	17	17	12	20	66
Eastern	7	17	17	11	52
Brong Ahafo	7	10	10	7	34
Volta	7	13	8	7	35
Central	9	9	11	8	37
Western	9	12	11	9	41
Northern	9	11	13	12	45
Upper East	5	4	8	6	23
Upper West	5	7	11	7	30
Total	91	119	123	102	435

Source: Based upon data provided by the MOH MCH/FP program.

Graduates of the program interviewed exhibited enthusiasm and an impressive level of knowledge about family planning. They had received 24 hours of classroom teaching and had 24 days of clinical practice. The director of the project at the School of Midwifery in Accra, however, indicated that the lack of high-caseload family planning clinics has been a serious constraint on the training program, particularly with regard to IUD insertion training. The director indicated that if it were not for PPAG clinics in Accra and Tamale the training program would have been seriously retarded.

JHPIEGO provided at least 120 IUD insertion kits to the trainees. Information concerning the number of IUD insertions that have been performed and the impact these nurse/midwives have had on contraceptive prevalence is incomplete. In January 1991, JHPIEGO carried out a small evaluation

at the clinic level which concluded that these service providers performed good-quality physical examinations of clients and that their clinical skills in IUD insertions were satisfactory. Most providers, however, were unable to recognize the immediate signs associated with perforation of the uterus during the passage of the uterine sound.

JHPIEGO has been trying since 1986 to revise the pre-service curriculum for nurse/midwives. A draft curriculum was presented to the National Association of Nurse Midwives in December 1989, but it has still not been approved, though the School of Midwifery is using the draft curriculum until it is approved.

6.5.4 Teaching Methodologies for Faculty and Nurse Educators

The targets are to hold a two-week workshop for 20 tutors to develop modular units for integrated MCH/FP curricula for nurse/midwives, to carry out three three-week courses for doctors and nurses in teaching methodology, and to evaluate at least 25 percent of first-year trainees as tutors. To date, 56 nurse tutors and 2 physician instructors have been trained. No evaluation has taken place.

6.5.5 Reproductive Health for Private Practitioners in Accra

The target was to train 40 doctors in IUD insertion so that they could serve as referral sites for midwives. No information was available on this activity.

6.5.6 Reproductive Health Update for District Medical Officers

The objective was to carry out eight one-day workshops for 50 district medical officers. No information was available on this activity.

6.5.7 Family Planning and Reproductive Health Update for General Practitioners

The targets were to update the skills of 20 doctors from Kumasi and 50 medical officers and private doctors from outside of Kumasi to train 50 interns in reproductive health, including VSC, at Komfo Anokye Teaching Hospital (KATH) in Kumasi, and to train 40 doctors to insert IUDs. According to the MOH, 20 physicians and 50 interns have been trained in minilaparotomy and 50 physicians have been trained in IUD insertion. The MOH indicated, however, that there has been no follow-up or evaluation of these trainees.

6.5.8 Training in VSC

Although the Contraceptive Supplies Project did not provide funding to the Association for Voluntary Surgical Contraception's (AVSC) work in Ghana, it is discussed here because it has been an integral part of USAID/Ghana's family planning strategy since 1986.

AVSC's first project had the goal of establishing VSC services in the Korle-Bu Hospital in Accra and the KATH center in Kumasi. The two projects were renewed in July 1988, and established the following targets:

Korle-Bu:	train 4 doctors in minilaparotomy carry out two seminars for 15 doctors and 20 nurses perform 300 VSC procedures
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KATH: train one additional VSC team
 hold a two-day seminar for 15 doctors and 25 nurses
 provide IEC training for nurse/midwives
 perform 340 VSC procedures

The most recent extension of the project with KATH, which covers the period January 1990-June 1991, has the goal of establishing five additional minilaparotomy service sites and training 40 nurse counselors.

Between April 1986 and December 1989, the Korle-Bu center was to perform 300 VSC procedures. Of nearly 2,000 procedures performed in 1987, only 10-20 were VSC; because of this low number, AVSC withdrew its support to the center in early 1990.

It is quite another story at the KATH center in Kumasi where the project's director is dynamic and committed to family planning. As a consequence, KATH has become the principal VSC service and training site in Ghana. The following table indicates the progress made at KATH since the beginning of the project:

Table 22
Number of VSC Procedures — KATH Center
1986 - 1991

Year	Minilap	Laparoscopy	Total
1986	21	3	24
1987	91	9	100
1988	85	20	105
1989	190	21	211
1990	240	5	245
1991	437	9	446

Source: Based upon data provided by AVSC.

In addition to the number of procedures accomplished, the KATH team received training in Nigeria and Kenya, and as of November 1991, the center had trained 5 VSC teams to work at KATH and 10 teams for other hospitals, and 50 counselors for VSC.

6.5.9 Training for MOH Personnel in Family Planning Counseling and Contraceptive Technology

This activity, which is part of the comprehensive IEC program described in Section 5, is included here because of the clinical aspect of the training. One of the goals of this \$871,535 buy-in to the PCS project, covering the period October 1987-September 1990, was to train 68 district health

management teams in family planning counseling and contraceptive technology; these teams in turn would train 4,000 MOH clinic personnel.

According to the MOH's Health Education Division, 5,154 Level B health clinic personnel were trained by the end of 1989. The following table shows the distribution by region:

Table 23

Level B Health Clinic Personnel IEC Training

Region	Number
Ashanti	731
Brong Ahafo	575
Northern	258
Upper West	157
Upper East	179
Central	520
West	219
Greater Accra	835
Volta	877
East	803
Total	5,154

Source: Based upon data provided by MOH Health Education Division.

The training courses were five workdays each, including two and a half days of interpersonal skills and two and a half of contraceptive technology. Two comprehensive training manuals were developed for this training, one of which has seven modules on family planning: 1) overview; 2) Ghanaian National Family Planning Program policy; 3) reproductive physiology and contraindications; 4) traditional methods of spacing and family planning; 5) modern family planning methods; 6) communications; and 7) family planning service delivery.

None of the training carried out under the project has had a systematic evaluation of its impact on knowledge and skills; for example, no one knows if the two and a half days dedicated to training Level B personnel in contraceptive methods is adequate.

The MOH has recently completed a preliminary analysis of the impact of this training on CYP, although the results have not yet been published. This analysis shows that there was a marked increase in CYPs during the training period and leading up to the IEC campaign which was to be launched in three of the 10 regions, and that there was a sharp downturn after the actual campaign

launch. It should be noted, however, that many factors are involved in variable levels of CYPs, not the least of which is stock-outs of contraceptives. There was enough indication of overall growth in MOH family planning services in 1989/1990 and in reports from service providers interviewed stating service delivery increases following training to suggest that the training had a positive, though unmeasured, effect on increasing the use of family planning methods.

6.5.10 Availability of Clinics for Training

The Ghanaian family planning program has historically been plagued by the lack of clinics with sufficient clientele for training purposes. Several project directors stated that one of the most productive clinics in the MOH's system is the sole-purpose clinic at Korle-Bu in Accra (see Table 24). There may be other such clinics in the system, but since no data is available on each clinic's caseload or performance at the central or regional offices, it is impossible to know. Staff at the Child Welfare Center in Kumasi stated that they are providing family planning services to an estimated 17 persons daily. In Koforidua, staff in the MOH clinic located next to the market indicated they are serving 10 persons per day, with the number reaching 30 on market day. Staff in the nearby PPAG clinic stated they are serving 20 persons per day.

Table 24

Korle-Bu Clinic Client Statistics

Method	Number of FP Clients			
	1989	1990	1991	Total
IUD	701	677	540	1,918
IUD Removals	303	345	295	943
Orals	402	538	301	1,241
VSC	72	108	21	201
Depo	263	398	357	1,018
Condoms	211	216	210	637

Source: Based on data provided by the MOH MCH/FP program.

If one considers that there are 260 workdays in the year, then the number of women served each day at the Korle-Bu clinic was 7.5 in 1989, 8.8 in 1990, and 6.6 in 1991. At this low level of productivity, it is not surprising that there is a scarcity of training sites. It is possible that the location of the clinic at the university is not convenient for the general population. Also, since MOH clinics close at 3:00 p.m. at the latest, all persons who would like to have family planning services in the evening do not have the opportunity.

6.6

Conclusions

1. Although the Contraceptive Supplies Project got off to a very slow start, the training targets in almost all respects have been met or exceeded. Since the midterm evaluation in March 1988, there has been a marked upswing in the training program.

2. The types of training that have been supported both abroad and in-country have been well selected and have provided a wide variety of technical and managerial skills. The combination of training abroad and on-site technical assistance in Ghana has institutionalized the capability to carry out MCH/FP training programs in the future. Only very specialized training would need to be met internationally.

3. Despite these achievements, the training program has several weaknesses:

- There is no one at the central level of the MOH with full-time responsibility for managing the national family planning training program.

- None of the Level B training carried out under the project has had a systematic evaluation of its impact on knowledge and skills; for example, no one knows if the two and a half days dedicated to training Level B personnel in contraceptive methods is adequate. Although it is commendable that the MOH was able to train so many Level B personnel in a relatively short period of time, there has been no systematic evaluation of this activity and one must wonder how well the trainees are able to provide family planning services.

- TBAs were not trained in oral contraceptives. This is a major conceptual and strategic flaw and a missed opportunity. Worldwide experience with using TBAs as deliverers of family planning services has been disappointing and this may turn out to be the case for Ghana, particularly if they are not permitted to distribute oral contraceptives.

- There has been little follow-up related to training; for example, it has not been determined how the original 120 IUD kits provided by JHPIEGO to MOH nurse/midwives are being used.

- The family planning curriculum in the Schools of Midwifery has still not been approved even though work on the curriculum began in 1986. Until sufficient time is blocked out for family planning in the training program, there will be no certainty that the students will graduate with enough knowledge and skills to eliminate the need for retraining.

6.7

Recommendations

37. Most training can be effectively done in Ghana. Therefore, only highly specialized training should be done abroad.

38. Priority should be given to training those who will work full time in family planning.

39. The number of high-caseload family planning clinics should be increased in both the public and private sectors in order to have sufficient sites for training.

40. A full-time family planning training director should be assigned at the central level in the MOH.
41. Training should be emphasized in the Brong Ahafo Region, Greater Accra Region, Ashanti Region, and Western Regions as part of an intensification of family planning service provision in those regions.
42. Efforts should be made to ensure that all courses given exclusively for family planning have adequate time to provide the necessary skills for the delivery of high-quality family planning services.
43. If any further training of TBAs is considered by USAID, it should only be on the basis of including training for the resupply of oral contraceptives, IEC for community outreach in family planning, and a better price arrangement and consistency of supply of contraceptives.
44. Training of both public and private sector midwives should continue at the rate of about 100 per year and should include training and equipment to prepare them to be able to make IUD insertions and extractions.
45. The family planning curriculum should be formalized in the Schools of Midwifery and Nursing.
46. The JHPIEGO teaching methodology training project should be evaluated before it is expanded.
47. JHPIEGO's experience in its private practitioners' IUD insertion training program in Accra should be evaluated before it is expanded. Midwives properly trained in IUD skills and equipped would rarely have to refer clients to these doctors.
48. Efforts should be made to ensure that the clinics that are or will serve as training sites are adequate in terms of space and construction. Related to this is the desirability of combining family planning services with VSC services in the same clinic. Such clinics should be mobilized in both the public and private sectors in all principal cities, beginning with the regional capitals noted in Recommendation 41 above.
49. All training activities should be evaluated to assess their impact on knowledge, skills, and performance in terms of family planning service delivery. This has not been done in the past, and it must be rectified immediately. Perhaps the evaluation of training could be done simultaneously, on a sample basis, in connection with the quality of care "situation analysis" of MOH clinics that is recommended in Section 7.

7. Quality of Care

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7. Quality of Care

7.1 Introduction

Experience indicates that a major contributing factor in the use and continuing use of contraceptive services is the quality of the services provided. Quality of care can be expressed in convenience to the clients (location, time, and cost); consistent availability of trained and well-motivated service personnel, informational material, and contraceptives; a mix of contraceptive methods that responds to clients' reproductive health requirements and individual choice; the way in which clients are dealt with to allay fears and respect privacy; and the physical conditions of the facility.

To assist in the assessment of quality of care, interviews were conducted with MOH officials and visits made to MOH, private midwife and PPAG clinics, and retail sales outlets in four regions and in the city of Accra. In addition, the following information was reviewed: evaluations of the TBA and GRMA training, a November 1991 report on visits to the 18 "best" clinics in the Ashanti Region by a panel of Ghanaian family planning leaders, and service statistics.

7.2 Convenience of Service to Clients

Section 2.5 of this report indicates that considerable progress has been made in bringing contraceptive services closer to the population through static facilities of the MOH, retail outlets of GSMP, and through the training of private midwives and TBAs. As noted in Section 6.4.1, however, the TBAs, presently the main MOH auxiliary personnel trained to be the family planning outreach to the community, have not been trained in either family planning communications or in the resupply of oral contraceptives. This substantially limits the effectiveness of this outreach channel, and reduces the convenience to the village consumer.

The addition of several thousand retail sales outlets and approximately 240 private midwives to the system substantially mitigates the problems of MCH/FP centers only being open until 3:00 p.m. five days a week. With several trained personnel for family planning in most of the facilities visited and some simplification of the procedures and tests required, there is reported to be less waiting time for clients in the centers.

The use of outpatient minilaparotomy procedures under local anesthesia provides a safer, more client-convenient approach to sterilization. The continuing tendency to insist on documented spousal consent and certain age and parity requirements, though not clearly articulated, do complicate matters. The limited availability of this method is the real negative in terms of client convenience, however.

There has been no substantive review of the impact of charges for contraceptives on client perception of the service. Contraceptives are substantially lower in price in Ghana than in other countries of West Africa, however. GSMP has been able to significantly increase prices with little apparent negative impact on sales. Thus, it appears that price is less of a deterrent for consumers than might have been expected.

7.3 Availability of Personnel, IEC Materials, and Contraceptives

One of the most encouraging aspects of the field visits was finding a cadre of enthusiastic personnel trained in family planning IEC and service delivery. The training described in Section 6 has produced adequate numbers of personnel at most of the centers to assure that someone is there to deliver family planning services at any time. This seems to be true even if some personnel are out of the clinic providing outreach services. The Ashanti report noted above states its findings as follows:

The attitude of staff was satisfactory, cooperative and enthusiastic. . . . It was worthy of notice that staff level of knowledge on the tenets of family planning was encouraging, however, it was disappointing to find that most of the nurses had no idea about the formula for working out the coverage or acceptor rate.

As discussed in Section 4.11, pharmacists and chemical sellers in the retail outlets who had received the contraceptive delivery training were found to be open in discussing the issue of contraceptive sales and generally positive toward the program.

There does not appear to be consistency in the availability of contraceptives and informational material in the MOH clinics. Although one or two of the centers visited had an adequate supply of IEC materials, the others did not. All of them had suffered contraceptive stock-outs and receipt of nearly expired contraceptives recently and in the past. The Ashanti report indicates

A sizable number of posters were available in all the health centers. Most of the clinics have quite a few while others were all worn out and require new ones. . . . Leaflets were not abundant in the system. A few that were available were hidden in cupboards and drawers contraceptives were generally in short supply in almost all health centers as a result of expired contraceptives and shortage of some others .

As indicated in Section 4, a variety of means and sources have been utilized by pharmacists and chemical sellers to assure their supply of contraceptives. When there are shortages of particular products, alternatives are generally found. Metal placards indicating GSMP services available were seen in the majority of the retail locations visited. Counter boards or bulletins explaining the use of contraceptives were not found, but point of purchase posters were seen in many outlets. Though not posted prominently as planned in the project, informational materials on pill contraindications and directions for use were found in the pill packages.

7.4 Contraceptive Mix

As noted Section 2.6, the program has had only limited success in including the more long-lasting, most effective contraceptives. There has been some growth in the availability of the IUD (see Section 6.4 for training of MOH personnel and private sector midwives). UNFPA has provided substantial quantities of injectables, but shortages have still occurred (the lack of mention of contraceptives in the UNFPA 1991-1995 program plan is disquieting in this respect). More serious is the extremely limited availability of the safest method for older, multiparous women, namely sterilization.

The continuing constraints on training outreach workers to provide resupply of oral contraceptives is an equally serious problem. This is true both in MOH training of TBAs and the World Bank supported CBD training being given at this moment by PPAG. Critical questions must be raised as to whether it is good public health practice to equip village workers with only the least effective and most expensive contraceptives — condoms and vaginal tablets. The breakdown of user confidence and the known health risks of contraceptive failure with this approach considerably outweigh the possible risks associated with the more widespread distribution of oral contraceptives. The availability of oral contraceptives in pharmacies and chemical shops has mitigated this problem to some degree.

7.5 Responsiveness to Client Concerns and Privacy

Due in some degree at least to the IEC training that over 5,000 Level B providers received (see Section 6.4.9), these personnel presented themselves and described their activities with confidence during interviews. There is reason to believe that they are competent in transmitting information to their clients, and their attitudes showed no signs of condescension or superiority. These personnel also wear "I Care" badges to indicate to clients that they have been trained to answer client concerns about family planning. On the other hand, the TBA operations research study undertaken by Columbia University (see Section 6.4.1) questioned women as to why they preferred TBAs to the health centers for delivery. The answers gave some indication that more improvement could still be achieved in the area of attitude toward clients.

Problems encountered in terms of concerns for privacy seemed more related to inadequacies in the physical facilities than to insensitivities on the part of the staff (see Section 7.6).

Specific themes in the IEC campaign addressed rumors about family planning. It is not clear that the health system is able to adequately allay concerns and fears, however. For example, some of the expressed fears about contraindications and dangers of hormones with regard to oral contraceptives seem to arise from the attitudes of health care providers themselves. It appears that their training, based on Western models, and the international press have exaggerated a concern for the real but limited risk of oral contraceptives. The instruction manual and the informational leaflets prepared for the IEC campaign are a step in the right direction. Many health care providers, however, have not assimilated the most up-to-date knowledge about the reduced risk of newer low-dose contraceptives or the recent clarification of the non-contraceptive health benefits of oral contraceptives. There seems little recognition that although there are contraindications for the use of the pill these same contraindications are substantially more serious for pregnancy. The physical examinations and the blood pressure, hematocrit, and urine tests performed may have some justification in specialized clinic settings. Research, including studies in Senegal, however, indicates that these tests have little if any value for predicting client success or health outcome in using oral contraceptives.

During site visits it was also noted that attention is being given to counseling in surgical training and appropriate informed consent forms are part of case file documentation.

In most instances, women were planning the family planning program and delivering the service. This speaks well for the recognition in Ghana of the importance of the role of women. This should have a positive effect on improving program responsiveness to the needs and interests of clients who generally are women. It also raises the question, however, of whether additional steps are required to reach the men who exercise considerable control over family reproductive decisions.

7.6 Adequacy of Physical Facilities

Site visits provided noteworthy examples of the kinds of clean and bright facilities that will be attractive and satisfying to clients. These included private sector midwives facilities, several facilities in the MOH system, and the PPAG clinic visited in Koforidua. Others for the most part were adequate for non-clinical contraceptive delivery (pill, condom, and foam). The conditions in some, however, were not conducive to quality performance in IUD insertion. In one hospital, the nurse trained in the JHPIEGO program for midwives had to concentrate IUD insertions on one day after 2:00 in order to have a room available. Under these conditions it was not surprising to note the precarious storage of equipment, contraceptives, and client records.

The facilities of the major program training center for midwives and for surgical teams at the KATH center in Kumasi were especially disappointing. An outstanding team of health professionals are trying to carry out their service delivery and training responsibilities in physical conditions that must be categorized as inadequate. The surgical facilities are crowded and not well maintained, and the various units are spread throughout the hospital in a way that makes communication and client flow difficult. The poorly located outpatient MCH/FP unit does not have enough space to ensure privacy for the clients. It is questionable whether the practical training should be continued in this location unless the facilities can be upgraded.

There was little in regional and district hospitals visited to indicate that appropriate facilities will be made widely available for elective sterilization procedures.

7.7 Conclusions

Despite the availability of trained, motivated, and competent personnel at the service delivery level, there continue to be serious problems in the quality of services related to 1) the non-availability of oral contraceptives at the village level; 2) the limited availability of the more permanent methods; 3) stock-outs of contraceptives and informational materials, 4) the inadequacy of facilities providing the more permanent methods, i.e., IUDs and VSC; and 5) the unwarranted concerns and fears of health delivery personnel regarding the risks associated with oral contraceptives.

7.8 Recommendations

50. Project management should develop a strategy for surveys that would provide for a "situation analysis" systematically reviewing the conditions and quality of family planning service delivery. This survey strategy should also include the concerns in social marketing and training evaluation discussed in Sections 4 and 6.

51. AVSC, together with appropriate Ghanaian institutions, should examine all the present sites where those trained in VSC are performing these services as well as those where future VSC services are contemplated. Special attention must be given to the physical facilities in the training center in Kumasi. This review should appraise the quality of services that are and can be provided in the present circumstances and should also include a realistic assessment of expectations, requirements, and constraints to developing quality services in the additional locations contemplated. The review should explore alternative approaches and organizational possibilities in private voluntary organizations or the purely private sector for expanding the availability of quality VSC services.

52. USAID and the MOH should continue to insist on securing the reclassification of oral contraceptives. This reclassification is an essential, though not sufficient in itself, element in allowing effective contraceptives to be available at the community level through a wider distribution network.

**8. Population Policy Development
and Strategic Management Policy Issues**

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8. Population Policy Development and Strategic Management Policy Issues

This section reviews the management policy recommendations of the midterm evaluation and identifies major areas of overall population and management policy relevant to implementation of the follow-on project. Many of these issues have been touched on in earlier sections of the report; they are repeated here to give a sense of the priority concerns in future project implementation.

Specific targets for policy development and management were not established in the original project design. The assumption was that the positive population policy concerns of the past would continue undiminished. The assumption was overly optimistic. Similarly, the project design may have underestimated the problems of developing mechanisms for coordination, planning, supervision, reporting, monitoring, and evaluation to achieve the overall objectives.

8.1 Midterm Evaluation Findings and Recommendations

The midterm evaluation provided a cogent assessment of shortcomings in project management. The report identified the requirements for better reporting, coordination and joint planning between the MOH, the Ministry of Finance, DANAFCO, and USAID. It encouraged a USAID management style that shifted more responsibility to national institutions, suggesting these institutions should be strengthened to assume this responsibility. The report concurred in the Ghanaian recommendation for the formation of a National Population Commission and in the interest of the MOH to have family planning assistance provided more in an integrated MCH or primary health care approach.

8.2 Population Policy Development and the Population Impact Project (PIP)

Following the 1986 National Conference on Population and National Reconstruction, the PIP project, which was designed to create a more favorable policy climate at government and society leadership levels, continued to grow and expand its influence in population policy development. With the assistance of the Innovative Materials for Population Action (IMPACT) and Resources for the Awareness of Population Impact on Development (RAPID) projects, a series of eight issues papers has been produced to bring the implications of rapid population growth to the attention of top government leaders, journalists, and leaders of public opinion. This series, written by respected Ghanaians in the fields of health, academia, and government, has addressed both the economic development consequences of population growth and the health implications of family planning. The papers are high-quality publications of 1,000 to 1,500 copies for direct delivery to a select list of officials and for use in seminars and discussion groups. Titles include *Population Growth and Development in Ghana*, *Maternal-Child Health and Family Planning in Ghana*, and *Population and Food in Ghana*. Another issue, *Some Implications of Rapid Population Growth in Ghana, Interviews with Members of Government*, was said to be one of the most useful in regenerating interest in population matters.

In addition, PIP used RAPID computerized models that were developed with Ghana-specific materials to present the implications of rapid population growth to varied leadership audiences. PIP also used television, radio, and newspaper articles to reach a broader audience; this contributed to

defusing some of the earlier newspaper criticism of family planning programs and created a more positive attitude toward population activities.

Thus far, however, these activities have not resulted in increases in practical support for family planning programs by the government through its budget or organizational structures in the Ministry of Health. The program is still too much in fact and in perception a donors' program.

Building on materials already produced under IMPACT, PIP could further assist the family planning program by increasing efforts to help policy leaders and service providers focus more balanced attention on the issue of the safety of modern contraceptives and relative risk associated with pregnancy. In cooperation with an institution similar to Family Health International or Columbia University, a qualitative KAP survey of nurse and midwife tutors, public and private sector health service providers and policy leaders could serve to identify continuing problems. These problems could be dealt with by joint sponsorship with institutions such as MOH, PPAG, and GRMA of policy workshops and scientific seminars with prominent international and Ghanaian leaders presenting the latest findings in these areas. Additional issues papers could be developed for use with policy leaders, as part of training curricula and in preparing informational materials for the general public.

PIP leadership is important through its chairing of the committee for designing the National Population Council ("Commission" in the midterm evaluation) which may become the "authority" referred to in the follow-on USAID project (see Section 8.4.6).

8.3 Strategic Management Policy Issues

8.3.1 Concentration of Effort

Section 2.5.1 highlights the considerable expansion of the numbers of delivery points where family planning information and services are in some fashion now available. This growth appears to have been driven more by equity and geographic distribution considerations than by a selective strategy of emphasizing more densely populated areas. Part of the difficulty of achieving sustainability in the social marketing program stems from the attempt to create a nationwide distribution network for contraceptives to reach, at considerable expense, the more far-flung corners of the country. Similarly, scarce MOH transportation and supervision resources have at times been dissipated in efforts to reach the more difficult locations. Certainly, from the perspective of basic human rights, it is appropriate to try to reach all the population as soon as possible. This may be more effectively and quickly accomplished, however, if increased efforts are applied where at least 50 percent of the population live. These areas of increased emphasis would be locations of greater population density, easier access, better communication, and where modernization contributes to greater readiness to use family planning services. While continuing programs in the rest of the country, a concentrated effort in the four regions of highest population density and greatest productivity of family planning users per distribution site could add an estimated 5 percentage points to the countrywide contraceptive prevalence rate. This intensified effort would include the development of a high-caseload, all-method private family planning clinic in each of four major cities. This would be consistent with the need to expand the availability of high-quality VSC facilities noted in Section 7.2. It would also mitigate the problems of securing adequate client caseloads for the practical training programs noted in Section 6.4.11. In addition, a level of effort would be required by the GSMP equal to that apparently accomplished in Greater Accra in the present project.

8.3.2 Contraceptive Mix

As indicated Section 2.6, the contraceptive mix of the program in the public sector has been skewed toward the provision of oral contraceptives, largely through static facilities. There has been insufficient availability of VSC to assure access to permanent methods for those for whom this would be the method of choice. The number of those trained for IUD insertion has grown substantially, but it is not known how many of them are properly equipped and delivering services in adequate facilities. There have been constraints on the delivery of oral contraceptives within the limited MOH outreach programs. These constraints have led to shortfalls in responding to client interests (see Section 7.2) and in achieving the greater impact on fertility of longer-acting and more effective methods.

Section 7.4 raises the issue of what might be the most effective way to increase the availability of VSC while also assuring high standards of service delivery. The midterm evaluation did not call attention to this essential requirement as it did to the need to assure that all services are voluntary and that appropriate documentation is maintained. The follow-on project projects a logical expansion of these VSC services into the regional and district MOH hospitals as well as some provision of assistance to the PPAG. The follow-on project also provides for considerably more technical assistance and modest inputs for facility and equipment improvement. Section 7.6 of this report expresses considerable concern about the physical facilities in which the highly motivated and competent professionals at the VSC training center in Kumasi are forced to function. Questions are raised about the proposed strategy for expansion through the MOH hospital network. Section 7.8 recommends a reappraisal of the realistic possibilities in this regard and suggests a search for alternative approaches. The end result of this activity may be a "new institution," perhaps similar to the private association for voluntary surgical contraception in Indonesia. The midterm evaluation suggests that the new project not create new institutions but build activities around existing networks. Generally that counsel is valid, but VSC may be an exception.

A major constraint to the increased use of effective contraceptives is the regulatory classification of oral contraceptives as "dangerous drugs" and the conservative attitude of health professionals toward their more widespread availability. The project paper indicated that the training of TBAs and primary health care brigades would prepare them to resupply oral contraceptive users at the community level. This was not done. The GSMP was able to address this issue with a training program for chemical sellers which enabled them to dispense orals within the system for distributing over-the-counter pharmaceuticals. The GSMP has been slow to reach out to other channels of distribution for various reasons; this policy constraint no doubt contributed to this slowness. Although the midterm evaluation was silent on the oral contraceptive policy constraint, this issue is key to future project success. It is encouraging that the follow-on project has identified this as one of the policy preconditions for the program grant funding. There had been considerable positive consensus developed within the MOH before this conditionality was established. This is not to say that full agreement has as yet been reached with all in the MOH or with the Pharmacy Board. It is a practical step in the right direction, but full deregulation will be required to utilize effectively the many "other private sector delivery networks" suggested in the midterm evaluation.

8.3.3 Relative Emphasis on the Public and Private Sector

It is in the best interest of the family planning program in Ghana for the future project to continue support of the public sector. A network of service delivery sites is in place staffed by capable personnel, many of whom have been trained under the auspices of the Contraceptives Supplies

Project. Although caseloads are much less than desired, these delivery sites have the capacity for considerably more. They provide a backdrop of clinical support justifying the recommendations for a more widespread distribution of contraceptives by village-level personnel. This system is the safety net for at least some who cannot afford higher-priced services at private physicians, midwives, or commercial outlets.

Despite the capable and enthusiastic leadership in the MCH and Health Education Divisions, it would not be realistic to expect anything more than marginal improvements in the MOH family planning program, which has some serious problems. Many of these problems are intrinsic to an institution with limited resources and many other responsibilities, including urgent curative care. Key changes in management policy could permit improvements in many of the problem areas with an infusion of effectively applied technical and material resources. The MOH is committed to an approach to family planning that has not been successful anywhere in the world, however. As long as it pursues this approach of decentralized integration with no clear mandate to focus personnel and program effort on family planning, there will only be limited increases in numbers of family planning clients served.

With the problems associated with the delivery of a focused family planning intervention within the public sector, one can understand why the midterm evaluation stated that "most of the project's resources should focus on the private sector." Generally, the private sector is found to be more efficient in the application of resources: it can be more flexible, changing direction more easily as new opportunities arise, and it is less constrained by policy or political considerations and may be prepared to pursue more focused objectives. The application of marketing principles is more likely to be found in the private sector. With its ability to hire and fire more easily and pay higher salaries, the private sector may be able to attract more qualified professionals. The private sector may be able to deal more effectively with men and adolescents or even some women for whom MCH services in a health center or hospital are not convenient or in an attractive location.

The follow-on project design demonstrates the acceptance of this recommendation to a degree that may not be warranted by the project experience. As pointed out in Sections 2 and 4, the GSMP has some limitations similar to some of those of the MOH. The new project design effectively addresses many of these problems. It is unrealistic, however, to expect the USAID-supported private sector activities to distribute contraceptives at a rate almost four times that of the MOH, as implied in the logframe of the follow-on project paper.

An alternate approach might be to provide more assistance to the PPAG, which in 1990 demonstrated that it was on the road to recovery from some previous problems. The distribution of contraceptives by PPAG in 1990 reached a level of approximately 59,000 CYP. PPAG may be reaching its absorptive capacity, however. The follow-on project paper notes PPAG expects to receive about \$740,000 annually for the next three years from the World Bank for its clinic program. Additionally, it will receive \$630,000 annually for three years for CBD activities. Presumably, PPAG will also continue to receive approximately \$800,000 annually from IPPF. It is unlikely that much additional USAID financial support will be required for its program activities in the near future. This could change if PPAG took a leadership role in VSC.

Since PPAG has been using the informational materials of the MOH Health Education Department, it would be well to assure that adequate quantities are produced for its needs as well as those of the public sector. At the same time, USAID would be well advised to provide PPAG whatever support it can utilize in terms of management consultation, training, MIS, modernized office equipment, etc. A.I.D. Cooperating Agencies have considerable experience in these fields and the management unit

of the USAID project should have expertise to share. This could be the point of contact with the PPAG to assist it to take full advantage of its World Bank grant, improve coordination between the public and private sector, and develop compatible reporting procedures.

There are plans to continue support to the GRMA. This probably could be expanded somewhat, especially if innovative ways were found to assist private midwives with the capital requirements to establish small maternity homes. With strengthened organization and management the GRMA can make an important contribution to maternal and child health and could provide modest levels of contraceptive services. The total CYP would be unlikely to exceed 40,000 per year even with substantial assistance.

8.4 Institutional Management Policy Considerations

8.4.1 General

As noted in the midterm evaluation, much of the reason for problems in meeting targets is to be found in the inadequate assumptions about the nature and capabilities of the several institutions involved and what it would take to modify or strengthen them to do the job. The midterm evaluation was not altogether helpful in encouraging a less activist role for USAID as it did not point out some necessary actions or organizational changes if Ghanaian institutions were to take a more effective role in project management. Nor did it clearly point out the numerous continuing project implementation and new project design actions that would require adding to USAID staff capabilities even in a more "hands-off" style of operation.

8.4.2 MOH

Ministries of Health, for purposes of efficiency in accomplishing their many responsibilities, sometimes choose to integrate a family planning program with primary health care or MCH programs. Ghana has chosen such an integrated (and decentralized) approach with the encouragement and support of its major donors and advisors, UNFPA and the World Bank. The challenge is to recognize some of the problems inherent in that approach as well as its positive aspects. Support elements need to be built in, such as full-time family planning leadership personnel at the central, regional, and district levels who will have special training in the management of family planning programs. Checkpoints need to be developed so that district, regional, and central staff are able to track expenditures, commodities, and service delivery performance down to the individual clinic level.

There is a high degree of commitment demonstrated by competent MCH personnel at all levels. Working under difficult conditions, staff show enthusiasm for their work and concern for those whose health they are trying to defend. Additionally, leadership has accomplished much in helping staff recognize the place family planning has as a positive health intervention. No doubt the IEC activities and family planning training of this project contributed to this awareness and encouraged personnel with various other service delivery responsibilities to assume a supporting role for family planning. To some degree, family planning has now become "everybody's business" within the MCH system. This is the case in many service delivery sites where it has resulted in more consistent availability of family planning services.

The negative side of that accomplishment is the difficulty in keeping what is "everybody's business" from becoming "nobody's business." With its integrated, decentralized approach the MCH division

has difficulty maintaining a clear focus on family planning. MCH does not have authority over the allocation of the human, financial, and commodity resources essential to the performance of its duties. Dilution of emphasis occurs in an organizational structure that assigns no one full-time responsibility for the family planning program within the understaffed MCH division.

Decentralization of responsibilities to the regional and district levels may eventually be positive. As these levels are not yet fully staffed, trained, and equipped to carry out their responsibilities, however, their contribution to improved program management is limited. Thus, the MCH division is inhibited in tracking the application of resources, monitoring and analyzing program performance, and reporting to leadership in the MOH, the Ministry of Finance, and donor agencies in a comprehensive fashion. Examples of this are the inability of the MCH to follow financial aspects of the program and difficulties in inventory management and the logistics of contraceptive supply. A proposed reorganization pattern of the MOH is not likely to mitigate this situation. Programmatic elements may be lost somewhere in directorates that appear more supportive than functional in nature.

The addition of anti-malarials and oral rehydration salts to the program is more justified on the basis of their contribution to other health interventions and not on any contribution they will make to improving the family planning program. It might even be better to delay any expansion of this product availability until contraceptive products are moving more freely through the social marketing channels.

8.4.3 PPAG

Since the project did not support the PPAG, a review of that organization was not included in the scope of work for this evaluation. Brief interviews with the PPAG executive director and staff, however, indicated that leadership capability in the organization could take advantage of assistance in improved management procedures.

8.4.4 GSMP

GSMP management issues described in Section 4 are largely related to the nature of private for-profit businesses (especially those with return on investment responsibilities to corporate ownership) which may not have been fully recognized in designing and implementing the Contraceptive Supplies Project. The present project is managed by one distributor with many other products competing for management attention and with a clear business mandate to distribute through the pharmaceutical network. Project objectives that were not obviously profitable in a relatively short period were difficult to attain. Uncertainties as to project continuity as short-term extensions were made did not generate a sense of long-term commitment on the part of the distributor.

The follow-on project has made some important improvements in creating the social marketing unit. The challenge it faces is to develop a marketing strategy and structure that will effectively utilize early and ongoing subsidies to create enough demand to support a self-sustaining, profit-driven mature distribution network. There will be substantial difficulties in attaching this project to any existing commercial institution, unless perhaps as a wholly owned subsidiary, while maintaining the integrity of its single purpose of generating commitment to the use of modern methods of family planning. This may require creating a new institution — another exception to the general suggestion of the midterm evaluation that no new institution be formed.

8.4.5 USAID

As recommended in the midterm evaluation, USAID substantially reduced its involvement in the direct management of the Contraceptive Supplies Project. This was partly in response to that recommendation, which sought to enhance GOG and DANAFCO (GSMP) management of the project. It also appears to have been a conscious, practical decision to enable the use of scarce USAID personnel in the development of the follow-on project. The design of this new project addresses the recommendations of the midterm evaluation more effectively than was done during the final implementation stages of the Contraceptive Supplies Project.

This use of USAID staff has been productive in many ways. For example, it is in the new project design that progress is likely to be made in regulatory changes. The new project found an innovative way to support local costs through the cedis generated by a program grant. Procedures for a GOG contribution to a return-to-project fund removes USAID from the intransigent problem of MOH inability to report on this fund in the Contraceptive Supplies Project.

The technical committee for the new project development including representatives of the MOH and the Ministry of Finance has served to improve communication and coordination and to create a much better sense of "project ownership" on the part of the GOG. The management structure for the new project, which calls for a prime contractor and expatriate advisors on the scene, can substantially reduce the management burden on the USAID.

In reducing its involvement in direct project management, however, USAID has placed more responsibilities on the Cooperating Agencies. The mission insisted on Ghana-specific reporting, and despite shortcomings in timeliness and completeness these reports were used for project monitoring. USAID contracted specific reviews by local audit firms and arranged for an outside evaluation of the GRMA training. Limited staff time, however, precluded follow-up on some of the findings of these reports as it did with immediate follow-up of some of the midterm evaluation recommendations. The expected increase in GOG management participation was only slowly forthcoming. Certain important implementation actions were not taken. For example, the recommended evaluation of all the training programs was not carried out, as was the case with the planned CPS to be conducted before this final evaluation. (USAID explains this as the inability of A.I.D./Washington to identify a suitable institution with the time to carry out this survey.)

Project implementation letters (PIL) were used to document proposed shifts in project funding. They were not, however, used to call attention to problems in project implementation such as difficulties in the port or shortfalls in securing local cost support. In the light of levels of contraceptive prevalence achieved, it is difficult to understand why two recent PILs stated to the government that the objectives of the project had been met. This is not to suggest that the USAID officer is not knowledgeable of project activities. Quite to the contrary, he has shown himself well informed and actively involved in seeking ways to improve performance without abrogating Ghanaian responsibility for project management, but there are only so many hours in the day.

8.4.6 The Proposed Population "Authority"

Probably in response to the direct recommendation of the midterm evaluation that a National Commission for Population be formed and to other recommendations that called for improved coordination, the new project design calls for the creation of a population "authority." This approach, however, has not been successful in other countries and also has as many similarities to as differences

from the unsuccessful Ghana National Family Planning Program. It would be useful to look at the early experience in Mexico where a similar commission did little to advance the objectives of fertility reduction. In Indonesia, on the other hand, a coordinating commission for family planning helped support the actions of effective implementing agencies focused on family planning with strong elements of vertical programming. Ghana is not likely to model its program on the aggressive approach in Indonesia, but it would do well to compare the effectiveness of Indonesia's broad national commission with that of the focused actions of their national family planning agency. The most instructive situation in Africa is Zimbabwe which, with a focus on family planning, has demonstrated a remarkable increase in contraceptive prevalence.

There is some concern that this commission, council, or authority, may focus more attention on non-family planning interventions than on the family planning program. The primary funding for this commission will be UNFPA. In its 1991-1995 program document, UNFPA states "As noted previously, such activities (non-family planning population approaches) have not been undertaken sufficiently given the preoccupations with family planning activities in the past."

A corollary to this concern is the potential the creation of this authority may have for giving a false sense of accomplishment in improving management while ignoring the management requirements of the implementing agencies. Efforts to improve analysis, monitoring, and coordination within the family planning program by whatever means will be welcome. There can be no substitute, however, for making these management improvements internal to the agencies carrying out the family planning programs.

8.5 Conclusions

1. Although there has been an improvement in the overall population policy climate in Ghana, this has not expressed itself in clear indications that a focus will remain on family planning, in financial investment at the national government level, or in demonstrating sufficient commercial market demand for contraceptives to justify risk involvement and commitment in the private commercial sector.

2. Through its chairing of the committee for designing the National Population Council, PIP is well positioned to deal with the general issue of government support for population programs and the relative emphasis that should be given to family planning within those programs. There is considerable interest in this council's being a "comprehensive" population authority, which in some sense it should be. This may well result, however, in diverting attention away from family planning programs in an unsuccessful search for other ways to reduce population growth. This can only serve to postpone making the national family planning program what it must become to deal effectively with the reproductive health and economic development consequences of Ghana's rapidly growing population.

3. The recommendations of the midterm evaluation have been substantially responded to either by solving the problems identified or building in improved policy and management structures in the follow-on project. Some necessary actions remain to be implemented, however. These include completing the planned-for evaluation of training and institutionalizing family planning training in pre-service curricula; carrying out an interim CPS or advancing the date of the next DHS; and solving the problem of delays in removing contraceptives from the port.

4. There are several areas in which there is need for review of new project assumptions: the degree to which the project can intensify its efforts in areas of highest population density and easiest access; the relative emphasis on public and private sector support; the strategy for the expansion of VSC; the management policy of the MOH which is committed to an approach of decentralized integration that has not been successful in reducing birth rates when tried elsewhere; the management style of USAID which should continue to place responsibility on GOG institutions and the social marketing unit to be formed, but with additional staff will take an active role in project implementation, monitoring, and supervision; and the proposed role of the new authority and ways to have it make the most positive impact on family planning, meeting the requirements to strengthen the management capacity of the implementing agencies.

8.6 Recommendations

53. The follow-on project should continue to assist PIP in its ongoing efforts to maintain and increase broad support for population efforts in general, and family planning in particular. To the degree possible, these emphases should be institutionalized in the curricula of the University of Ghana, Legon.

54. The project should assist PIP with efforts through KAP studies of health personnel and policy makers and through scientific seminars and publications to improve understanding of the safety and risks of various contraceptives and their positive health benefits.

55. To the degree it continues to be involved in the National Population Council, PIP should encourage the council to focus adequate attention on family planning programs and ways to support improved management of these programs by the several implementing agencies.

56. USAID and GOG should take the necessary action to complete the unfinished business of the Contraceptive Supplies Project which is critical for developing a baseline for initiating the new project, making strategic decisions in developing training plans, and assuring adequate supplies of contraceptives to the service delivery channels. These actions are as follows:

- completing the planned evaluation of the training,
- institutionalizing family planning training in pre-service curricula,
- carrying out an interim CPS or advancing the date of the next DHS, and
- solving the problem of delays in removing contraceptives from the port.

57. USAID and GOG should go forward with the implementation of the new project, but together with the prime contractor should review the assumptions, targets, and management policies in the light of the findings of this evaluation. Of signal importance to securing project success consistent with the GOG stated policy of fertility reduction, the following actions are considered of the highest order of priority:

- The demonstration of national support for this population policy through the inclusion of support for family planning activities as line items in both the capital and recurrent cost budgets of the national government;

- **The demonstration of USAID support for this program through the addition of two professional staff in its Health, Population, and Nutrition division (a technical assistant for child survival activities and an experienced Ghanaian physician manager), by expeditious arrangements for resident technical assistance personnel in the social marketing unit, by the long-term commitment of adequate resources to provide for a strongly managed and aggressive social marketing program, and by support of actions within the MOH designed to place greater institutional and programmatic emphasis on family planning within the health system.**
- **The development of coordination and support mechanisms for the social marketing program by USAID and the GOG that foster freedom of operation for the private sector using established business practices within overall policy guidelines; procedures should be put in place to provide rapid response to bureaucratic or regulatory constraints on project progress. Among other support required, the study of self-sustainability in the context of total country family planning programs should be given priority attention.**
- **The strengthening of the MCH/FP programmatic units at the national and regional levels with staff, space, and equipment to have adequate full-time professional attention to family planning program planning, management information systems, inventory control, and monitoring of program performance.**
- **Continuing and increasing support for the Health Education Department to allow it to plan, manage and evaluate a broad IEC campaign in coordination with the GSMP, PPAG, and others.**
- **The exemption of the oral contraceptive from pharmaceutical regulation, based on the review of worldwide research on the safety of newer contraceptives, their non-contraceptive health benefits and the relatively much higher risk to mothers and children of unwanted or unhealthy pregnancies.**

9. Lessons Learned

9. Lessons Learned

1. **The development of a national family planning program is a more labor intensive undertaking than is often recognized by those who allocate personnel either in USAID or in host country institutions. An effective program requires policy development, training, research, IEC, contraceptive procurement and distribution, improving the quality of care, and developing appropriate systems for supervision, monitoring, and evaluation. A program which includes the public and private sectors and uses a variety of direct USAID procurement and contracted and centrally procured technical assistance presents a formidable network of responsibilities. These cannot be handled by a few part-time persons either in USAID or host country institutions. Integrating these responsibilities with other activities such as maternal child care or decentralizing many of the functions complicates the task rather than making it easier.**
2. **A corollary requirement is the need for the project to support sufficient personnel for management and implementation of private sector social marketing activities until the growth of effective demand has demonstrated sufficient commercial viability to attract financial and personnel investment by the local cooperating firm.**
3. **Demand creation efforts must involve policy development actions with policy-making groups and with program implementation policy makers, and must also involve the training of program personnel both in service delivery and communication skills. A broad IEC outreach to the community and to potential clients is essential to convert awareness of family planning to use of family planning. Demand is strongly influenced by the quality of the service with consistent availability of trained personnel able to respond to concerns and allay fears. The degree of demand for family planning will not be known until such time as quality family planning information and services have been made available to potential clients in a convenient, culturally acceptable fashion.**
4. **An effective national family planning program requires national government commitment that goes beyond policy statements and is effectively demonstrated by allocations of financial and personnel resources consistent with the critical importance of the effort.**
5. **The Ghana program has demonstrated the validity of lessons learned elsewhere — that there can be no quality family planning services without a full and constant supply of contraceptives. Inadequacies in procurement procedures, shipping, port removal, and internal distribution have left end-use distribution points with frequent stock-outs, undermining the efforts to improve IEC and train large numbers of service delivery personnel.**
6. **The requirements for local cost financing must be recognized more clearly and addressed more effectively than is often the case (perhaps as excessive emphasis is placed on demonstrating low recurrent cost requirements and the potential for early self-sufficiency). In the case of this project, many of the management personnel shortages and problems in logistics, supervision, and IEC can be attributed to inadequacies in local cost financing.**
7. **Social marketing programs must realistically appraise the practical commercial objectives of the cooperating private sector enterprise. Support must be provided to capitalize on its capacity while avoiding expectations of performance beyond those dictated by profit-motivated business management practice.**

8. It is unlikely that a program will succeed with the kinds of constraints on the use of oral contraceptives which derive from a pharmaceutical classification as "dangerous" drugs. If additionally there are also severe limitations in the availability of the safest and most secure method for older, multiparous women (namely, sterilization), a program like Ghana's can engage in much effective action to increase interest in family planning but produce disappointing results in increasing contraceptive prevalence.

9. Program objectives of reaching a higher percentage of the population with family planning services will be more effectively and more efficiently reached by intensification of effort in the areas of greater population density, easier access, and more readiness to make use of family planning services. Geographic expansion should be at a pace consistent with program abilities to support the activities in the more distant locations and the capacity to absorb the additional costs of reaching the less accessible, lower volume areas.

Annexes

Annex A
Conclusions

Annex A

Conclusions

Service Delivery Impact

1. The difficulties encountered in attempting to measure project effectiveness confirms the need for a Contraceptive Prevalence Survey and the need to review the targets proposed for the follow-on project.

2. The project has seen growth in the contraceptive prevalence rate, but not enough to reach the GOG population growth rate target nor to affect the crude birth rate. The possible trend toward an annual increase of 1.5 percentage points as indicated by the CYP figures for 1988 and 1990 does not mean that the program is efficient or cost effective as far as family planning is concerned. Although the GOG has valid reasons for expanding health services in geographical terms, there is also an urgent need to speed the process of adopting family planning methods to reduce fertility to achieve GOG population policy goals. At the present level and pace of contraceptive use, it will take the program some 20 years to produce a visible effect on the fertility rate. By that time, the Ghanaian population will be more than 30 million. The Greater Accra Region will be reaching a population density of at least 1,400 people per square kilometer. The country will be hard pressed to create the necessary social and economic environment to satisfy the needs of a population more than twice the size of the current population.

3. The project has experienced some stagnation, requiring new strategies to increase CPR to meet follow-on project targets. To reach the growth rate goal of 1.75 percent (which had been set for the year 2000), even in the next decade, adjustments in strategy are necessary to reduce the plateauing effect observed in program performance and to prevent a long period of stagnation which could be fatal at this early stage of program development.

4. There has been a great deal of expansion in provision of services, but not enough productivity. The growing demand for services such as delivery, prenatal and postnatal care, immunizations, nutrition, etc., must be met. In these conditions, family planning is the new arrival competing with other MCH services for MOH resources. After three years of this project, the results are poor at the clinic level.

The family planning experience in almost all countries shows that the integrated approach is not successful in reaching adequate levels of contraceptive prevalence. Without questioning the intentions of the GOG to expand health services to all the areas of the country, even the most remote and inaccessible ones, the family planning program has to develop new strategies to become cost effective and produce the results that the government wants to obtain.

It would be best to concentrate efforts on making the clinics that are already in the MOH system work effectively and efficiently to serve family planning clients before expanding the system further. The MOH's current system of 584 clinics providing family planning is already over-extended. This is manifested by the fact that each of these clinics is serving, on average, less than one woman per day per clinic.

A feasible, cost-effective approach would be to establish a few well-located, high-caseload, sole-purpose family planning clinics providing all contraceptive methods. These exclusive family planning clinics would have well-trained and motivated personnel, and would operate in adequate facilities with the aim and the capacity of producing up to 75 CYPs per day. These levels could be attained through making VSC readily available on an easy-access, outpatient basis, assuring full supply of other longer-acting contraceptives (Norplant, IUD, and injectables), and making the provision of oral contraceptives essentially an over-the-counter process. The approach could be implemented in one clinic in each regional capital city starting with four regions. At the same time, the action of the clinics would be supplemented with concentrated efforts of the social marketing or a community-based distribution program, or both. It is estimated that together these actions would produce an additional 10 percent prevalence in those four regions. This would amount to an additional 5 percent for the entire country. (See Annex G for a more detailed explanation of this approach.)

5. The method mix needs to change towards more permanent and semi-permanent methods to meet the GOG population policy goal and the follow-on project targets. While the MOH program appears to have a more balanced approach, the GSMP sells a substantial quantity of less-effective methods. If the MOH TBA outreach activity and the PPAG community-based distribution (CBD) program continue as presently being implemented, they will also only increase the use of condoms and vaginal tablets (see Section 7.4). The low participation of permanent and semi-permanent methods, like surgical contraception and IUDs, makes the program weak in its ability to obtain high prevalence rates, and also reduces the chances of having a significant impact on fertility.

Logistics and Management Information System

1. Contraceptive stock-outs are a source of frustration for family planning activities. The serious problems still present at the international and local levels need to be solved by A.I.D./Washington, USAID, and the GOG. Contraceptives have been introduced into the country about to expire, and then they, as well as other shipments, remain in port longer than they should. The result has been that they do not serve the purpose of protecting the women and men in fertile age against pregnancy; instead, significant quantities have had to be destroyed.

2. Transport of contraceptives is another problem. The vehicles available to the MOH are too busy with other activities to cope with the distribution needs of the family planning project.

3. The storage facilities are inadequate in clinics and districts. Inventory controls and commodity storage practices are below the required standards.

4. It is now universal practice for the clinics to produce monthly reports, but the many compilations are compromising the accuracy of the data and missing valuable information for management purposes at each level of aggregation.

5. At some point in the future, it would be worth considering the development of a computerized system that would reduce the work of staff, improve accuracy, and maintain disaggregated information for analysis. The appropriate time for this would be when the current MIS and the logistics system are fully in operation, and when there is a guarantee that automation in family planning would be used to serve family planning activities as its primary goal.

Social Marketing of Contraceptive Products

1. DANAFCO has done a fine job preparing and disseminating the required financial and commodity documents. It has also made solid progress in the development and use of marketing plans, and provides sales data quarterly for estimating CYP.

2. DANAFCO's ability to provide total management of the marketing program still leaves much to be desired. Three factors have been significant contributors to this problem: a) the temporary nature of project extensions and the hiatus in management contracts, b) insufficient understanding of the levels of financial and managerial support needed for an "orphan" business division, and c) the continuing lack of experience and authority vested in full-time project management.

3. Considerable effort has been devoted to responding to the midterm evaluation recommendations to create an advisory council and to provide technical assistance and training to improve GSMP management's understanding and use of marketing and management skills. Reality dictates, however, that it takes years of experience to provide the kind of total project management needed and expected; i.e., marketing experts capable of understanding and using, with full sophisticated authority, market data and market development tools and approaches and resources.

4. Significant progress has been made in expanding the number of retail outlets with the potential for distribution of condoms, VFTs, and oral contraceptives through the pharmaceutical network (pharmacists, chemical sellers) since project inception. Efforts to expand the distribution outlet types beyond the pharmaceutical chain have been slow, however, and small in terms of impact. The emphasis has been primarily on very small outlets — market women, filling stations — rather than on some alternatives which represent far larger and far more rapid possibilities for extending program outreach, such as the military or clinics in large factories such as the Ashanti Gold Mines.

5. DANAFCO's ability to provide the wide distribution network anticipated for GSMP products has been severely limited by the lack of provision for salesmen dedicated solely to such service.

6. The lack of a dedicated sales force has also resulted in those retail outlets that have a demand for contraceptive products resupplying themselves wherever possible, including MOH and PPAG clinics, other retailers, and "agents."

7. One result of this multi-channel approach to resupply has been a proliferation in the private sector of all brands of contraceptive products available through donor programs. In terms of creating a social marketing program that offers a wide choice of methods to the ultimate consumer at convenient locations for purchase, this turn of events is to be welcomed. In addition, this proliferation of "competitive" products in the marketplace could serve to keep retail prices low in an environment pressing for price increases to meet project objectives of self-sustainability. At the same time, given all the data in this report on CYPs, unit sales, and market share of GSMP, MOH, and PPAG, the outputs anticipated in the follow-on project appear significantly out of line with what the distribution system can be reasonably expected to deliver. The follow-on project paper projects commodities needs for the MOH and GSMP as follows:

	<u>MOH</u>	<u>GSMP</u>
Condoms	13,800,000	39,000,000
Orals	3,000,000	39,000,000
VFTs	5,200,000	76,000,000
IUDs	50,000	5,000
Norplant	1,000	---

These output figures do not correlate with the detailed cost estimates for commodity provision outlined in another section of the same project paper, which correlate much more closely with the reality of distribution in-country at this time.

8. Significant advances have been made in creating an environment accepting of family planning specific-brand advertising (including oral contraceptives). This situation can be used to advantage to inform consumers about the reasons for selecting a particular method and brand, as well proper use and contraindications. Awareness must be converted into use if population growth rates objectives of the GOG are to be met.

9. Some key market research questions critical to any well-informed evaluation of the overall effectiveness of GSMP have not yet been addressed. One is a retail audit to evaluate effectiveness of the distribution system in urban and rural areas of each region and to understand the nature and extent of price points of a variety of "competitive" family planning products widely available in retail outlets. Another is a quantitative pricing study to determine impact of various price strategies on both market share and project self-sustainability. A third is some kind of quantitative consumer knowledge, attitudes, and practice (KAP) study which could generate some hard data on source of supply and geographic dispersion of users, etc., along with prevalence of specific reasons for non-use among non-users and benefits derived from use among users.

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10. Information critical to understanding how the retail trade is performing by geographic area and outlet type is still not being accumulated and analyzed in a way that would increase management responsiveness to market conditions, even though this information exists and is used for financial analysis.

11. Self-sustainability is a responsible long-term objective for the private sector social marketing aspect of any national family planning initiative. To achieve such a goal, however, requires setting carefully analyzed and documented parameters for conditions to be achieved in government policy and regulations in order for there to be a significant impact on the possibility of business development. Setting those parameters requires commitment to measurable accomplishments convertible to business development impact on the part of donor agencies, host governments and implicated ministries as well as primary contractors and private sector social marketing units.

Public Sector IEC Activities

1. Ensuring that top-level GOG decision makers are included in the evolving Ghana family planning efforts being funded by A.I.D. is clearly something that must be addressed by both the U.S. Embassy and USAID mission through person-to-person technical and political dialogue.

2. The strong motivational work being carried out by outreach efforts to village communities cannot be expected to translate into contraceptive prevalence unless the services required are also available and well publicized in a positive environment. This can be achieved through strengthening community-based distribution.

3. The leaflets, booklets, and flip charts produced have been widely distributed and have been well received by both MOH health clinic workers and NGOs, but both groups need more of them. Outreach efforts undertaken by health clinic workers at the village level are often hindered by the lack of these teaching aids as well as vehicles.

4. The data generated by the PCS household interviews and focus groups are largely unusable and unused. More than enough data already exists within the PCS raw data and other research data available on constraints against and motivations for family planning, however, to form the basis of a strategic mass media motivational campaign. This campaign would be designed to overcome constraints and to help individual men and women make responsible family planning decisions.

5. Posters received an inordinate emphasis in IEC campaign budgeting, given that they were primarily used as top-of-mind awareness generators within health clinics. Those who have decided to explore family planning alternatives for themselves and their families need informational assistance, such as the brochures and booklets and video shows and radio informational programming.

6. National radio is now being used to combat rumors and encourage male participation in family planning decision making, and to promote responsible decision making by men and women through the soap opera, "Family Affair." These are excellent tools for disseminating carefully prepared, well-researched, and culturally sensitive family planning informational and educational messages.

7. Substantial emphasis is placed on both qualitative and quantitative research to pretest and evaluate all MOH IEC and GSMP motivational efforts in the follow-on project. Although this kind of research is critically important, it needs to be kept in mind that unrealistic demands for multiple complex research initiatives can squander the project's human and financial resources.

Training of Public Sector Health Care Providers and Private Sector Midwives

1. Although the Contraceptive Supplies Project got off to a very slow start, the training targets in almost all respects have been met or exceeded. Since the midterm evaluation in March 1988, there has been a marked upswing in the training program.

2. The types of training that have been supported both abroad and in-country have been well selected and have provided a wide variety of technical and managerial skills. The combination of training abroad and on-site technical assistance in Ghana has institutionalized the capability to carry out MCH/FP training programs in the future. Only very specialized training would need to be met internationally.

3. Despite these achievements, the training program has several weaknesses:

- There is no one at the central level of the MOH with full-time responsibility for managing the national family planning training program.

- None of the Level B training carried out under the project has had a systematic evaluation of its impact on knowledge and skills; for example, no one knows if the two and a half days dedicated to training Level B personnel in contraceptive methods is adequate. Although it is commendable that the MOH was able to train so many Level B personnel in a relatively short period of time, there has been no systematic evaluation of this activity and one must wonder how well the trainees are able to provide family planning services.

- TBAs were not trained in oral contraceptives. This is a major conceptual and strategic flaw and a missed opportunity. Worldwide experience with using TBAs as deliverers of family planning services has been disappointing and this may turn out to be the case for Ghana, particularly if they are not permitted to distribute oral contraceptives.

- There has been little follow-up related to training; for example, it has not been determined how the original 120 IUD kits provided by JHPIEGO to MOH nurse/midwives are being used.

- The family planning curriculum in the Schools of Midwifery has still not been approved even though work on the curriculum began in 1986. Until sufficient time is blocked out for family planning in the training program, there will be no certainty that the students will graduate with enough knowledge and skills to eliminate the need for retraining.

Quality of Care

Despite the availability of trained, motivated, and competent personnel at the service delivery level, there continue to be serious problems in the quality of services related to 1) the non-availability of oral contraceptives at the village level; 2) the limited availability of the more permanent methods; 3) stock-outs of contraceptives and informational materials, 4) the inadequacy of facilities providing the more permanent methods, i.e., IUDs and VSC; and 5) the unwarranted concerns and fears of health delivery personnel regarding the risks associated with oral contraceptives.

Population Policy Development and Strategic Management Policy Issues

1. Although there has been an improvement in the overall population policy climate in Ghana, this has not expressed itself in clear indications that a focus will remain on family planning, in financial investment at the national government level, or in demonstrating sufficient commercial market demand for contraceptives to justify risk involvement and commitment in the private commercial sector.

2. Through its chairing of the committee for designing the National Population Council, PIP is well positioned to deal with the general issue of government support for population programs and the relative emphasis that should be given to family planning within those programs. There is considerable interest in this council's being a "comprehensive" population authority, which in some sense it should be. This may well result, however, in diverting attention away from family planning programs in an unsuccessful search for other ways to reduce population growth. This can only serve to postpone making the national family planning program what it must become to deal effectively with the reproductive health and economic development consequences of Ghana's rapidly growing population.

3. The recommendations of the midterm evaluation have been substantially responded to either by solving the problems identified or building in improved policy and management structures in the follow-on project. Some necessary actions remain to be implemented, however. These include completing the planned-for evaluation of training and institutionalizing family planning training in pre-service curricula; carrying out an interim CPS or advancing the date of the next DHS; and solving the problem of delays in removing contraceptives from the port.

4. There are several areas in which there is need for review of new project assumptions: the degree to which the project can intensify its efforts in areas of highest population density and easiest access; the relative emphasis on public and private sector support; the strategy for the expansion of VSC; the management policy of the MOH which is committed to an approach of decentralized integration that has not been successful in reducing birth rates when tried elsewhere; the management style of USAID which should continue to place responsibility on GOG institutions and the social marketing unit to be formed, but with additional staff will take an active role in project implementation, monitoring, and supervision; and the proposed role of the new authority and ways to have it make the most positive impact on family planning, meeting the requirements to strengthen the management capacity of the implementing agencies.

Annex B
Recommendations

Annex B

Recommendations

Service Delivery Impact

1. During the implementation of the follow-on project, one sole-purpose, high-caseload family planning clinic offering all contraceptive methods should be established in the regional capital city of the four regions showing the most promise for growth in contraceptive prevalence: Greater Accra Region, Eastern Region, Brong-Ahafo Region, and Ashanti region.
2. Efforts should be made to create the necessary conditions for the GSMP to intensify the distribution of contraceptives in the four regions mentioned above.
3. The oral contraceptive pill should be declassified and made available to field workers such as CBD workers and TBAs and other alternative outlets for purchase mentioned in the social marketing section of this report (Section 4). The MOH and private organizations should be encouraged to accelerate the positive trend toward the use of more effective methods, including oral contraceptives and especially the IUD and VSC.

Logistics and Management Information System

4. USAID should ask the follow-on project providers of technical assistance for MIS and logistics to review project paper assumptions and to make contraceptive projections reflecting the history and distribution capacity of the program.
5. A.I.D./Washington and USAID must assure that no contraceptives expired or about to expire will be sent to the program, and the program must dispose of expired contraceptives as soon as possible, following the USAID regulations for A.I.D.-donated contraceptives.
6. With A.I.D./Washington assistance, USAID should monitor contraceptive requests at all stages of the process (manufacture, shipment, arrival at European port, transshipment, arrival in Ghana) and should keep the GOG informed of shipment status.
7. A.I.D./Washington should ensure that every shipment is made with the necessary documents to clear the contraceptives through customs in the shortest time possible.
8. A.I.D./Washington should respond to the mission's requests for quarterly statements of the contraceptives account.
9. USAID and the MOH, together, should solve the problem of contraceptives in port. If no clear-cut solution is found, USAID should look for alternative solutions, for example, contracting with the private sector to clear shipments and deliver them from the port to the MOH central warehouse.
10. Future technical assistance for the MIS and logistics systems should concentrate in assisting the GOG to provide additional training in sound warehousing and storage practices, and to train appropriate personnel to analyze and use service statistics at all levels and in both sectors (GSMP and MOH).
11. At least three vehicles should be devoted to family planning only. These vehicles should be used for supervision and supplying contraceptives to the most densely populated regions and districts in the MCH/FP program. USAID should consider providing them through the follow-on project.
12. Continuing users and total users should be deleted from the MIS reporting form. Further, one single report that can be sent to both donors, USAID and UNFPA, should be created and implemented.

Social Marketing of Contraceptive Products

13. The follow-on project recommends the creation of a social marketing unit. The unit should be dedicated exclusively to distribution and marketing of family planning products until the business is mature, stable, and the contribution to the prevalence target has been met. It is equally important that this unit should be a Ghanaian firm.

14. The social marketing unit must be managed by top-level Ghanaians with sufficient experience to manage a mature distribution and marketing business. Management must be supported, as required by the follow-on project, by technical assistance from resident expatriates having expertise in social marketing and business development strategies, including MIS. This expertise is critical in developing a self-sustaining business, but should have been substantially imparted to Ghanaian management by the time the business has met its goals for maturity.

15. The social marketing unit should be structured so that all funds, equipment, vehicles, and personnel are dedicated solely to its primary business: marketing and creating a reliable and effective distribution network for family planning products. Where there are existing distribution chains such as DANAFCO and G.B. Olivant, they should be used if they are appropriate and cost-effective. A monopoly of distribution by one chain, however, would be counter-productive to the long-term potential for the two primary project goals of availability and sustainability.

16. Two options for organizing such a unit should be given particular attention: a) it could be a wholly owned and autonomously managed subsidiary of an existing Ghanaian firm, or 2) it could be an independent organization with the long-term business objective of becoming a wholesaler and retailer (primary marketer) of a variety of family health products after its family planning business objectives have been met.

17. The primary contractor for the follow-on project must review the commodity needs projections as soon as possible after arrival in Ghana to ensure that commodity provisions are in line with projectable sales expectations for MOH and GSMP, given the levels of advertising and IEC support expected to be fulfilled at that time.

18. Clinics in the private sector which serve substantial populations are an obvious and as yet unexploited possibility for extension of GSMP products and even DANAFCO products. These large population-base possibilities should be given a higher priority in the follow-on project.

19. A detailed business plan including commitments to funding and measurable levels of performance against objectives must be written and executed.

20. Because commitment to use of modern family planning products in Ghana is so low, a second-generation campaign should make every effort to convert concept awareness into brand awareness, and brand awareness into use. Brand awareness does not convert to use unless people understand the connection between a brand name and some personal benefit to be derived from use which they find meaningful.

21. The possibility of private stock ownership of the social marketing unit — by its parent if a wholly owned subsidiary or by private investors if independent — should be given serious consideration, at least on an experimental basis. Investment by private sector Ghanaian nationals — individuals or corporations in related businesses and even by the GOG — would address the critical business development factor of shared commitment through shared risk. Such investment would also generate working capital, and perhaps foster cooperation through commitment.

22. Benchmark quantitative market research studies must be undertaken (and repeated in five years to measure impact and adjust strategy) to develop a coherent strategy of distribution goals and motivational advertising weight and content. These studies are necessary to provide the entire social marketing

effort — private and public sectors alike — with quantitative data on the urban and rural retail environments as well as with quantitative data on contraceptive prevalence, and consumer knowledge, attitudes, and practices regarding family planning methods and brands. A CPS or repeat DHS could respond to some of these questions. No family planning program can be comprehensively managed in a culturally sensitive and highly targeted way without such critical data.

23. An MIS must be implemented in the social marketing unit which includes reliable statistics on retail outlet movement by retail outlet type and geographic location, so that trends in business development or loss can be monitored and strategic responses can be implemented.

24. A pricing study should be implemented to determine what the proper prices should be for products targeted at lower, middle, and upper socio-economic groups.

25. The potential impact of the proliferation of donor contraceptive products in the private sector distribution chain must be examined seriously in order to develop a coherent and responsive strategy. Questions of impact to be addressed are a) responsiveness to consumer needs for choice and convenience and b) ability to set and assess prevalence contribution targets for the GSMP, MOH, and NGO project components.

26. A distribution strategy must be created which concentrates on efficient and reliable delivery to the most densely populated and accessible areas of Ghana first and then to less accessible and less densely populated areas.

27. Consideration should be given to creating a distribution cost equalization fund within return-to-project funds to offset the incremental cost of distribution to less accessible population groups.

Public Sector IEC Activities

28. Full emphasis should be placed on creating a comprehensive strategic plan for mass media dissemination of motivational information designed specifically to convert the high levels of awareness of the concept of family planning and methods into informed commitment to the practice of family planning. The emphasis should be placed on motivating people to come to points of service and product delivery, and not on those who have already arrived at the points. Short informational campaigns constrained by budgetary shortfalls are not acceptable. The campaign must legitimize family planning practices and must make family planning practice relevant to the individual in terms of personal benefits to be derived from family planning.

29. In the follow-on project, the mass media radio campaign should dominate national IEC campaigns, with secondary emphasis placed on the regional grassroots activities such as *durbars* and concert parties. The latter are excellent programs, along with the role-plays implemented by clinic outreach personnel, but they reach an extremely limited audience by comparison with the radio audience.

30. A.I.D. should reallocate resources to ensure full funding of IEC motivational radio campaigns (as well as GSMP campaigns) for the full five years of the follow-on project. MOH funds allocated for this purpose in the follow-on project should be redirected to the sole purpose of developing and maintaining on air the "Family Affair" radio soap opera, which also promotes equally the MOH's six primary health initiatives: malaria, EPI, MCH, family planning, nutrition, and diarrhea. Characters representing public sector health workers at the community and family planning clinic levels should be included in scripts. This approach will further enhance the self-image of public sector health workers, as well as their image in the minds of policy decision makers and the people of Ghana who will come to them for information and services.

31. The budgetary commitment to posters should be considerably reduced, while the budget should be increased for radio; reproduction of informational leaflets, brochures, and flip charts or other

teaching aids; billboards; and vehicular and resource support for role-plays and video presentations on family planning.

32. The follow-on budget should provide funds for whatever levels of duplication of the multi-method booklet are necessary. If the specific flyers for each method have been evaluated and found to be helpful to potential clients, they too should be abundantly available for clinic clients to take home — clearly visible on walls or counters at all clinics. Also, method-specific flyers should be made available in local languages, minimally in Akan.

33. Consideration should be given in the follow-on project to providing all the IEC materials — flip charts, booklets, flyers — to NGOs engaged in the family planning initiative in Ghana.

34. The male motivational campaign should be evaluated and adjusted as necessary at the end of its current air schedule (March 1992). The project should give priority to ensuring there is a well-targeted male motivational campaign in the follow-on project. Men in Ghana are key decision makers influencing child-bearing decisions and must be drawn into the effort to plan children responsibly. The data in this report clearly indicate that men have not achieved the same levels of awareness of the range of family planning options available in Ghana as women. An environment must be created through the IEC campaign in which men and women are encouraged to discuss family planning together.

35. Project market research needs should be reviewed by a technical assistance specialist in market research for the purpose of designing a minimal research plan to cover the needs of the program for both development and evaluation purposes.

36. The follow-on project calls for major mass media campaigns for both GSMP and IEC efforts, yet does not provide a meaningful budget for advertising, and places financial responsibility for all IEC mass media development and dissemination on MOH funding. If this activity is to be supported from the non-project assistance funds of the follow-on project, special attention should be given to budgeting and making available adequate funds for this essential element of the program. There should be separate budgets for GSMP motivational advertising and Health Education Division IEC motivational public education spots and programming. These are complementary programs, to be sure, and must be well coordinated, but their purposes are entirely different and each one needs to be given full support for the role it plays in converting awareness to commitment to family planning.

Training of Public Sector Health Care Providers and Private Sector Midwives

37. Most training can be effectively done in Ghana. Therefore, only highly specialized training should be done abroad.

38. Priority should be given to training those who will work full time in family planning.

39. The number of high-caseload family planning clinics should be increased in both the public and private sectors in order to have sufficient sites for training.

40. A full-time family planning training director should be assigned at the central level in the MOH.

41. Training should be emphasized in the Brong Ahafo Region, Greater Accra Region, Ashanti Region, and Western Regions as part of an intensification of family planning service provision in those regions.

42. Efforts should be made to ensure that all courses given exclusively for family planning have adequate time to provide the necessary skills for the delivery of high-quality family planning services.

43. If any further training of TBAs is considered by USAID, it should only be on the basis of including training for the resupply of oral contraceptives, IEC for community outreach in family planning, and a better price arrangement and consistency of supply of contraceptives.

44. Training of both public and private sector midwives should continue at the rate of about 100 per year and should include training and equipment to prepare them to be able to make IUD insertions and extractions.

45. The family planning curriculum should be formalized in the Schools of Midwifery and Nursing.

46. The JHPIEGO teaching methodology training project should be evaluated before it is expanded.

47. JHPIEGO's experience in its private practitioners' IUD insertion training program in Accra should be evaluated before it is expanded. Midwives properly trained in IUD skills and equipped would rarely have to refer clients to these doctors.

48. Efforts should be made to ensure that the clinics that are or will serve as training sites are adequate in terms of space and construction. Related to this is the desirability of combining family planning services with VSC services in the same clinic. Such clinics should be mobilized in both the public and private sectors in all principal cities, beginning with the regional capitals noted in Recommendation 41 above.

49. All training activities should be evaluated to assess their impact on knowledge, skills, and performance in terms of family planning service delivery. This has not been done in the past, and it must be rectified immediately. Perhaps the evaluation of training could be done simultaneously, on a sample basis, in connection with the quality of care "situation analysis" of MOH clinics that is recommended in Section 7.

Quality of Care

50. Project management should develop a strategy for surveys that would provide for a "situation analysis" systematically reviewing the conditions and quality of family planning service delivery. This survey strategy should also include the concerns in social marketing and training evaluation discussed in Sections 4 and 6.

51. AVSC, together with appropriate Ghanaian institutions, should examine all the present sites where those trained in VSC are performing these services as well as those where future VSC services are contemplated. Special attention must be given to the physical facilities in the training center in Kumasi. This review should appraise the quality of services that are and can be provided in the present circumstances and should also include a realistic assessment of expectations, requirements, and constraints to developing quality services in the additional locations contemplated. The review should explore alternative approaches and organizational possibilities in private voluntary organizations or the purely private sector for expanding the availability of quality VSC services.

52. USAID and the MOH should continue to insist on securing the reclassification of oral contraceptives. This reclassification is an essential, though not sufficient in itself, element in allowing effective contraceptives to be available at the community level through a wider distribution network.

Population Policy Development and Strategic Management Policy Issues

53. The follow-on project should continue to assist PIP in its ongoing efforts to maintain and increase broad support for population efforts in general, and family planning in particular. To the degree possible, these emphases should be institutionalized in the curricula of the University of Ghana, Legon.

54. The project should assist PIP with efforts through KAP studies of health personnel and policy makers and through scientific seminars and publications to improve understanding of the safety and risks of various contraceptives and their positive health benefits.

55. To the degree it continues to be involved in the National Population Council, PIP should encourage the council to focus adequate attention on family planning programs and ways to support improved management of these programs by the several implementing agencies.

56. USAID and GOG should take the necessary action to complete the unfinished business of the Contraceptive Supplies Project which is critical for developing a baseline for initiating the new project, making strategic decisions in developing training plans, and assuring adequate supplies of contraceptives to the service delivery channels. These actions are as follows:

- completing the planned evaluation of the training,
- institutionalizing family planning training in pre-service curricula,
- carrying out an interim CPS or advancing the date of the next DHS, and
- solving the problem of delays in removing contraceptives from the port.

57. USAID and GOG should go forward with the implementation of the new project, but together with the prime contractor should review the assumptions, targets, and management policies in the light of the findings of this evaluation. Of signal importance to securing project success consistent with the GOG stated policy of fertility reduction, the following actions are considered of the highest order of priority:

- The demonstration of national support for this population policy through the inclusion of support for family planning activities as line items in both the capital and recurrent cost budgets of the national government;
- The demonstration of USAID support for this program through the addition of two professional staff in its Health, Population, and Nutrition division (a technical assistant for child survival activities and an experienced Ghanaian physician manager), by expeditious arrangements for resident technical assistance personnel in the social marketing unit, by the long-term commitment of adequate resources to provide for a strongly managed and aggressive social marketing program, and by support of actions within the MOH designed to place greater institutional and programmatic emphasis on family planning within the health system.
- The development of coordination and support mechanisms for the social marketing program by USAID and the GOG that foster freedom of operation for the private sector using established business practices within overall policy guidelines; procedures should be put in place to provide rapid response to bureaucratic or regulatory constraints on project progress. Among other support required, the study of self-sustainability in the context of total country family planning programs should be given priority attention.
- The strengthening of the MCH/FP programmatic units at the national and regional levels with staff, space, and equipment to have adequate full-time professional attention to family planning program planning, management information systems, inventory control, and monitoring of program performance.

- **Continuing and increasing support for the Health Education Department to allow it to plan, manage and evaluate a broad IEC campaign in coordination with the GSMP, PPAG, and others.**
- **The exemption of the oral contraceptive from pharmaceutical regulation, based on the review of worldwide research on the safety of newer contraceptives, their non-contraceptive health benefits and the relatively much higher risk to mothers and children of unwanted or unhealthy pregnancies.**

Annex C
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Annex C

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Annex D
Scope of Work

SCOPE OF WORK
FOR FINAL EVALUATION

GHANA CONTRACEPTIVE SUPPLIES PROJECT (PROJECT NO. 641-0109)

AUTHORIZATION DATE: 8/4/85
COST: \$10 MILLION
LOP DATE: SEPTEMBER 1985 - JUNE 1992
PACD: JUNE 30, 1992

BACKGROUND

On August 8, 1985, the Assistant Administrator for Africa authorized the four-year Ghana Contraceptive Supplies Project (641-0109) for a total life-of-project amount of \$7.0 million. This was to be supplemented by \$576,000 from centrally funded projects, and by \$3.273 million in host country contributions.

The Mission signed a grant agreement for the project with the Government of Ghana on September 19, 1985. The original project activity completion date was September 18, 1989, which has been extended to June 30, 1992 to allow completion of the scope of work.

The purpose of the project is to assist Ghana in increasing the voluntary use of safe, effective and appropriate contraceptive methods by its population. This purpose is to be accomplished by making an adequate supply of contraceptives and other family planning services available to the Ghanaian public on a continuing basis through the existing service delivery network of the Ministry of Health (MOH) and through the development of a private sector Contraceptive Social Marketing (CSM) Program.

Over the Life of the Project, the Public Sector MOH component seeks to:

- a) create a logistic management and reporting system to ensure the availability of contraceptives to MOH outlets;
- b) train personnel in family planning to staff of all MOH clinics and community health programs; and
- c) increase knowledge and use of contraceptives by means of informational programs, instruction by family planning personnel, and the ready availability of contraceptives.

The MOH is responsible for organizing, coordinating and implementing all public sector family planning activities. For specific tasks the MOH has received technical assistance from regionally and centrally funded agencies including Johns Hopkins University Population Communication Services (JHU/PCS), Johns Hopkins University Program for International Education in

Gynaecology and Obstetrics (JHPIEGO), Association for Voluntary Surgical Contraception (AVSC), Management Services for Health (MSH/INTRAH), Centers for Disease Control (CDC) and the Columbia University Center for Population and Family Health.

The private sector CSM component of the project seeks to :

- a) establish a private sector contraceptive distribution network which is expected to become largely self-financing by the end of the project;
- b) develop an effective private sector contraceptive supply system, allowing for expansion of the retail sales network;
- c) train a cadre of retailers and marketing staff in family planning and program management; and
- d) increase consumer awareness of contraceptives through advertising promotion and marketing activities.

In March, 1986, the Government of Ghana entered into a host country contract with DANAFCO Ghana Ltd., a pharmaceutical manufacturing company to organize and implement the private sector CSM Program.

A strategic decision was made during project design that technical support would be obtained piecemeal from existing central or regional cooperating agencies/contractors, and that no unified country team or prime contractor would be utilized.

The Mission has actively utilized central or regionally funded project which complement the Ghana Contraceptive Supplies Project in developing its overall population program strategy. Instead of the \$576,000 originally planned to come from centrally funded projects, a total of over \$3.2 million has been used from these sources to support the technical assistance needs. Included in the broad Mission efforts are activities such as training and family planning service delivery by private sector midwives in conjunction with the American College of Nurse-Midwives, ACNM; surgical contraception organized by the Association for Voluntary Surgical Contraception (AVSC), biomedical and social research conducted by Family Health International; family planning curriculum development and physician and nurse training in laparoscopy and reproductive health assisted by JHPIEGO; demographic and health data collection organized and assisted by Westinghouse/Demographic and Health Surveys; family planning information, education and communication campaigns supported by Population Communication Services of Johns Hopkins University; and population policy development in conjunction with the Population Reference Bureau/IMPACT and RAPID II and III projects with the Futures Group.

Objectives of the Final Evaluation

As stated in the project paper, the final evaluation "will focus on project success in achieving training, sales and contraceptive use objectives". An equally important objective is to determine the lessons learned from the implementation of the project that are important for implementing the follow-on project.

A mid-term evaluation of the project was carried out in March/April 1988 in which a series of recommendations were made to steer the project to accomplish its objectives. The final evaluation will also examine the extent to which the recommendations of the mid-term evaluation were implemented and the extent to which they modified project accomplishments.

STATEMENT OF WORK

With the guidance and direction provided by USAID/Ghana and under the supervision of the team leader, the evaluation team will address the following questions:

I. Project Impact:

- 1.. To what extent has the project met, exceeded or failed to meet each of the outcome goals? What factors contributed to exceeding or failing to reach these goals?
2. The GSMP uses retail outlets to provide goods and services, while the MCH uses public facilities. Compare the population groups reached by the GSMP with those reached by the MCH? What are the relative advantages/disadvantages of each approach? Are there any groups that are systematically missed by both approaches? What can be done to reach these groups?
3. Are different groups being reached by ORS and by Family Planning commodities? Is there any measurable synergism between these two products? What implications are there for the addition of anti-malarials to the social marketing line of products?
4. Have the training activities in the public sector had a measurable effect on family planning acceptors?
5. What has been the effect of training pharmacists and chemical sellers in extending reach of family planning supplies, and has this been effective in attaining project goals?

6. How well have other distributors, such as NGOs, TBAs, Registered Midwives and Market Women been incorporated into both public and private sector distribution systems? What else needs to be done to improve this?

II. Mid-Term Evaluation Impact:

7. Is there any evidence that the conclusions of the mid-term evaluation should be amended in light of the past two years of project implementation?
8. Since the mid-term evaluation what progress has been made on each of the following MOH and CSM program components:
 - management capacity, including program planning, administration and monitoring, budget and financial management and supervision, service site management;
 - training of personnel, supervision and oversight of participating institutions and maintenance of relevant standards of service;
 - information, education and communication (IEC) strategies in terms of their cultural sensitivities, appropriateness, effectiveness and potential impact;
 - commodity procurement, storage, distribution and resupply systems;
 - compilation, analysis and utilization of service statistics; and
 - inter-agency (i.e., between MOH divisions, between Ministries, between GOC and donors, and among donors) communication and coordination. How have these role changes affected overall project implementation?
9. What additional technical inputs need to be made during the follow-on project to consolidate and institutionalize the above activities?
10. The Mid-Term evaluation made many comments on USAID's role in project management, and made suggestions for the future. To what extent has USAID's responsibilities and leadership roles in project planning and implementation changed in light of this evaluation?

III. Management and Sustainability:

11. How effective are operating procedures and policies of MOH, MFEP and DANAFCO? Are there any procedures or policies that need to be modified?
12. How has the project management structure, utilizing a large number of central and regional contractors under the direct control of the USAID HPN office, rather than a unified in-country team, facilitated or impeded project objective achievement?
13. Has USAID's role in managing and providing oversight to the project been effective? How can USAID change its role to make it more effective?
14. Given the history of the current project, what needs to be done over the next five years to ensure the financial and institutional sustainability of project activities after the completion of USAID assistance?

References:

The official references for this evaluation are the signed project agreements, subsequent amendments, project implementation letters, and approved financial reports. The project paper and its appendices, project authorization project correspondence, PIO/Ts/Cs/Ps, project implementation reports, consultants trip reports, mid-term evaluation report, research findings, health sector assessments and financial reports, studies requested by USAID/Ghana. All these documents will be made available to team members at the time of the evaluation.

Evaluation Team Composition

The evaluation will be a joint effort between USAID and GOG. This will be supported by a team of Ghanaian and international experts.

The external evaluation team will be composed of a management/evaluation specialist, a contraceptive social marketing specialist, a family planning program specialist and a logistics management specialist. The management/evaluation specialist will be designated team leader. Team members will work with identified Ghanaian counterparts who have knowledge and background related to specific project components. The Ghanaian members will be selected by the GOG with concurrence by USAID and will serve as in-country resource persons and contacts for external evaluation team members in addition to being full team members.

Qualification of each of the external team members will be as follows:

All non-Ghanaian team members will be fluent in English, skilled in report writing, and completely familiar with word processing, either Word Perfect or Wang, to the point that they can function without secretarial support. (Some secretarial support is expected for processing final drafts)

1. **Management/Evaluation Specialist:** Graduate level training in administration, management or social science with field research experience, working experience in LDCs, preferably Africa. Previous experience in developing large-scale population/family planning projects/programs. Experienced in leading similar teams is essential. Knowledge of and experience in A.I.D. mission management. Experience in conducting AID evaluations. Experience in managing population projects is desirable. (Expected to be a centrally hired contractor)
2. **Family Planning Program Specialist.** Expert in broad range of family planning program elements (information, education and communication (IEC) training, service delivery standards and contraceptive supply management). Experience with family planning and health program implementation in the African setting; graduate degree in population, health or health-related field. Experience in dealing with centrally and regionally funded population projects and cooperating agencies. (Expected to be REDSO/WCA health/population officer)
3. **Contraceptive Social Marketing Specialist:** Expert with state-of-the art knowledge of social marketing program concepts and program options; extensive field experience in social marketing, particularly commercial retail sales of contraceptives; knowledge of advertising and marketing of contraceptives in African milieu; experience in training, supervision and management of retail pharmacists, chemical sellers and/or vender-type sellers. Graduate training in behavioral science. (Expected to be contractor)
4. **Logistics Management Specialist:** Expert in assessing, developing and managing public and private sector contraceptive logistic systems in developing countries. No specific educational requirements, since experience in evaluating similar situations is the critical skill needed to perform the task. (Expected to be contractor)

EVALUATION METHODOLOGY

1. Preparation

Prior to the implementation of the evaluation, a joint meeting will be held by the parties involved (USAID, NFPF, MOH) to develop mutually agreeable terms of reference, to discuss the local expertise needed to successfully implement the evaluation and the overall parameters of the evaluation, and to plan in-country agenda for the external evaluation team.

2. Field Evaluation

The field evaluation will include three phases: orientation, fact-finding, and data analysis and development of recommendations.

Upon arrival of evaluation team USAID Population Development Officer will discuss with the team the purpose and objectives of the evaluation to ensure mutual understanding. In addition, the team will be briefed on the project, its progress and status of host country participation in the evaluation and logistical arrangements.

Orientation: For the initial few days of the in-country evaluation, the project evaluation team and designated Ghanaian counterparts will meet to refine the terms of reference; delineate responsibilities among the team members; review scopes of work; read project documents; develop evaluation tools where necessary; hold meetings under USAID leadership on evaluation expectations; and conduct team building exercises.

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3. Evaluation Implementation Schedule:

Complete SOW and PIO/T	USAID/Accra	July, 1991
Select Team Members	Cont./USAID	August, 1991
Collect Documents	USAID/MOH	September, 1991
Review SOW and Plan of Action	USAID/MOH	September, 1991
Conduct Evaluation	Team	Oct. 1-30, 1991
Formal Briefing	Team	Oct. 28, 1991
Final Document	Contractor	Nov. 28, 1991

Reporting Requirements

At the end of the field evaluation, the team will prepare and deliver a formal briefing to USAID and the GOG which will include salient observations, conclusions and recommendations.

A draft evaluation report will be submitted to USAID/Ghana prior to the departure of the team leader. The contractor (POPTECH) will be responsible for preparing the final report. 20 copies of the report will be submitted to USAID within 30 days of the completion of the in-country evaluation work.

Evaluation observations, findings and recommendations will be reviewed by USAID and the GOG.

The minimum required format for the evaluation report is as follows:

- Executive Summary
- Project Identification Data Sheet
- Table of contents
- Body of Report
- Appendices

The format of the body of the report will be structured by the team with USAID guidance to best present project findings. The first appendix will be a compilation of all findings.

Twenty copies of the final report will be supplied to the USAID population office within sixty days of Mission approval of the draft.

The USAID Population Development Officer will complete the final AID Evaluation Summary Form upon receipt of the final report.

Funding

The Family Planning Program Specialist will be provided by REDSO/WCA at no cost to the Mission. The three specialists will be contracted through an add-on to the POPTECH project (DPE-1024-2-00-8078.00). The contractor will provide computers for the three individuals supplied through the add-on, and will provide final production facilities for the evaluation report. The Mission will assist with arrangements for local transportation, secretarial and logistical services in Ghana, but these will be paid for under the contract.

Annex E

**Problems Encountered in Measuring Impact
against Project Targets**

Annex E

Problems Encountered in Measuring Impact against Project Targets

The initial targets to be achieved by the project in relation to users and contraceptives distributed were established in the project paper for the original period 1986 to 1988. However, targets were not updated to reflect the extension of the project for three more years, so current targets remain those originally projected for 1988. Substantial difficulties were encountered in assessing target achievement by the project because of inconsistencies in the proposed performance measurements. The basic targets of the project paper were expressed in increases in contraceptive prevalence. However, additional targets proposed for CYP and users would not produce these expected CPR increases.

The table below indicates 1986-1988 targets proposed in the project paper for couple of years of protection (CYP), acceptors, and users as a percent of MWIFA. It shows contraceptive prevalence rate (CPR) targets compared with the estimated rates achieved by the program. It also estimates what CYP would have to be to achieve the CPR desired.

Outcome		Targets			Achievements	
		1986	1987	1988	1990	%
CYP	MOH	56,372	99,025	105,969	93,280	88.0
	GSMP	22,308	100,386	156,156	88,557	56.7
Acceptors	MOH	77,890	131,560	138,504	238,513	172.2
Users as a percentage of MWIFA	MOH	3.5*	5.7*	6.2*	3.2**	51.6
	GSMP	1.0*	4.5*	7.0*	3.0**	42.8
Estimated CYPs required to accomplish the proposed prevalence rate	MOH	91,980	155,154	174,800	93,280	53.4
	GSMP	26,280	122,490	197,400	88,557	44.9

Source: Based upon data provided by the MOH and GSMP.

* CPR: estimates (past month use, all methods) generated by dividing current users by MWIFA times 100.

** CCPR: generated by dividing CYP by MWIFA times 100 (equivalent to CYP as a percent of MWIFA).

The last two rows of the table above show the estimates of the CYPs that would be required to obtain the targeted prevalence rates. The table shows that these figures are much higher than the ones proposed in the project paper, which indicates that the CYPs proposed do not correlate with the contraceptive prevalence targets. Thus, when the correct CYPs are used, the level of accomplishment of the project is reduced. At the same time, the difference in performance between MOH and GSMP is also substantially reduced.

This leads to a discussion of a related problem in evaluating project impact which is the lack of correlation in MOH and GSMP data. First of all, the table shows that significantly higher CYP growth was projected for GSMP than for MOH; in fact, the ratio is 7 to 2. Thus, while the data show that MOH achieved 88 percent of its CYP target and GSMP achieved 56.7 percent of its target, GSMP also achieved 95 percent of the MOH CYP level.

Inconsistency in method of calculation of CYP between the MOH and GSMP appears to produce higher contraceptive prevalence rates for the MOH. For example, with almost the same number of CYPs projected for 1991 for both the MOH and GSMP, there is more than one percentage point difference in the calculation of MOH and GSMP contraceptive prevalence rates. As a second example, although GSMP was projected to have almost 50 percent more CYPs than the MOH in 1988, the calculation shows GSMP producing only one percentage point more of contraceptive prevalence than the MOH. Differences in method of calculation between MOH and GSMP are not clearly explained in the project paper, and it is not clear whether they reflect differences in the method mix, the expected dynamics of each project, or both.

A major difficulty encountered in evaluating the impact of the project is the fact that a contraceptive prevalence survey (CPS) was not undertaken before project end. Therefore, there is no hard data against which to measure CPR achievement against targets. It is necessary to use another measurement, which is CYP derived CPR. The difference between the two measures is this. CPR is generated by dividing the number of current users found in a CPS by the number of MWIFA times 100 to create a percentage. CYP derived CPR (CCPR) takes the estimate of couple years of protection based on sales data and divides this estimate by MWIFA times 100.

One problem inherent in using CCPR is that its accuracy is dependent on the project dynamics and method mix. For example, one CYP may mean one woman using contraceptives during one year, or twelve women using contraceptives for one month. Theoretically, a contraceptive prevalence survey could count one user in the first case and as many as 12 in the second. However, this extreme would not be encountered with reasonably large numbers of users in the program. Programs with similar CPR but different combinations of dropout and new acceptor rates also are likely to have different CCPR. The method mix also influences the level of CCPR due to the deferred effect of the permanent and semi-permanent methods on couple years of protection, which are in fact accumulated to the rate in the current year. For example, a woman accepting an IUD is given a CYP value of 2.5 years. However, all 2.5 years are counted as CYP in the year of acceptance.

A second problem inherent in using CCPR is the fact that sales do not necessarily equate to effective use. For example, purchasers may be retailers as well as end users. Also, end users may buy but may not use product effectively. This is true of both the MOH and GSMP data.

It has been argued that the number of acceptors would be an appropriate measurement. However, number of acceptors is less reliable than the CYP because of the lack of standard interpretation of the definitions for new and continuing users at the service level, which originates multiple counting in the service statistics. Using acceptors as the indicator would show that 172 percent of the proposed MOH target had been met. This suggests tremendous success of the MOH project that is not sustained by the other data used to measure project performance. Additionally, the GSMP is not designed to collect user statistics. Contraceptive sales is the only effective measure, expecting this to be backed by contraceptive prevalence surveys.

Thus, even though CCPR has limitations as a measurement, there is no other more reliable indicator available.

However, it is recognized the information obtained for the GSMP project does not reflect actual consumer use, since it records warehouse sales to retail outlets. This is particularly important during the expansion period of the project because many new outlets are receiving stocks for the first time. Thus sales data reflect increases in the distribution pipeline, not actual use.

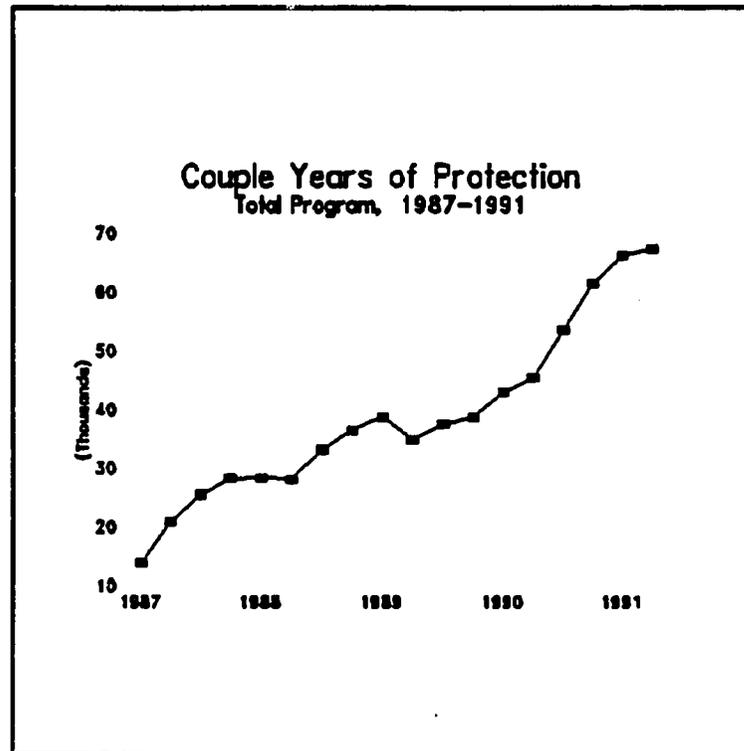
A similar problem exists with the MOH figures. MOH sales are supposed to reflect contraceptives sold to clients. There are two problems inherent in this supposition. First, sales to clients do not necessarily translate into effective use. Second, the proliferation of MOH products in the private sector outlets indicates that not all MOH clients are end users. Thus, the indicators obtained from the available data are not totally comparable among the sectors or with the goals established.

In summary, the evaluation compared couple years of protection derived contraceptive prevalence rate or CCPR with project paper CPR targets as the best approach available given the inconsistencies in project paper user projections, the lack of user statistics and the absence of a contraceptive prevalence survey.

Annex F
Total Country Program Performance

Annex F

Total Country Program Performance



The graph above shows the trend of the aggregated CYPs of the three sectors (MOH, GSMP, and PPAG) of the family planning program of Ghana by quarter, smoothed by plotting moving averages. The program had a first plateau during 1988 and a second plateau during 1990. The trend of the curve also slows down during the two quarters of 1991 suggesting a new plateau during this year.

As it has been explained in the main body of this report, the program has the largest increase in the past two years due to the big expansion of both the MOH and GSMP also by the introduction of new product in the GSMP sector. The expansion does not mean necessary actual use but providing stock to any outlets for the first time. The total program may continue the slow growing trend because the expansion at the ministry of health is not likely to continue at the same pace and increasing productivity is difficult in the integrated system. DANAFCO may increase its volume of sales if they expand the coverage of outlets particularly in the more densely populated regions. The plateauing effect will continue in the future unless certain measures are taken.

Annex G

Proposal to Intensify Services in Four Regions

Annex G

Proposal to Intensify Services in Four Regions

Unlike the situation in many developing countries, Ghana has a high population density. Two thirds of the population are considered rural according to the census definition, but most of the people are concentrated around the main cities. Greater Accra Region has nearly 700 people per square kilometer. There are some small empty spaces in the north, but on the whole the country is densely populated (about 60 inhabitants per square kilometer). Four regions located in the south of the country, covering only one third of the total surface, have almost 50 percent of the population and probably the best of the available resources. These regions are Greater Accra, Brong Ahafo, Ashanti, and Central. They offer probably the best conditions in which to operate a well-established well-supervised family planning program. The following are the main characteristics of these regions:

1. Greater Accra Region, with 687 people per square kilometer, has the highest population density in the country, the best family planning productivity level based on CYP per clinic, and the second best contraceptive prevalence. Accra, the capital city, is located in this region, with accompanying economic and political resources.
2. Ashanti Region, with a population density of 102, is the third region in CYP productivity and contraceptive prevalence, and its main hospital has the sterilization program..
3. Central Region has 133 people per square kilometer, and is fifth in CYP productivity and fourth in prevalence.
4. Brong Ahafo Region's population density is 38 people per square kilometer. It is the second region in productivity and has the highest prevalence rate.

Regions 2,3, and 4 have similar characteristics except that the population density of Brong Ahafo is far below the level of the other two. However, considering that this region has the population concentrated around its capital city, Sunyani, it makes it similar to the other two in the sense that the target women are easy to reach.

The project paper for the new project does not make clear the expected role PPAG or the relative contribution expected of MOH and GSMP to CPR. As noted in the body of this evaluation, the projections of contraceptive requirements are confusing. Thus, for this hypothetical example we assume the present relationships will continue.

Assuming an equal distribution of the goal for 1996 proposed in the project paper (15 percent prevalence by 1995) for the three sectors, MOH, CSM and PPAG, each sector has to achieve 5 percent prevalence and the program has to generate about 540,000 CYPs in the last year. If the new four sole-purpose high-caseload family planning clinics and the intensification of the GSMP or any other community distribution of contraceptives are established to supplement the action of the GSMP, an additional 180,000 CYPs could be generated in the proposed four regions. In this way the total CYP prevalence rate could be 20 percent. This goal is achievable. The calculations are shown below.

Hypothetical Example of Increased CPR from Intensification of Family Planning Service Delivery in Four Regions:

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Current and Proposed Performance of the Four Regions

MOH MCH Program without Intensification

Regions	CYPs	1990 CCPR	Expected to be obtained in 1995 without intensification	
			CYPs	CCPR
Greater Accra	16256	4.9	31366	7.5
Brong Ahafo	17591	6.2	33942	9.6
Central	9665	3.6	18649	5.6
Ashanti	21157	4.3	40822	6.6
Total 4 Regions	64669	4.7	124778	7.2
Other 6 Regions	28620	1.9	55220	2.9
Total	93289	3.3	180000	5.0

GSMP, CSM Program without Intensification

Regions	CYPs	1990 CCPR	Expected to be obtained in 1995 without intensification	
			CYPs	CCPR
Greater Accra	26363	11.3	50868	12.1
Brong Ahafo	7688	--	14835	4.2
Central	8537	0.2	16472	4.9
Ashanti	16332	4.2	31512	5.1
Total 4 Regions	58921	4.3	113687	6.6
Other 7 Regions	26959	1.8	66313	3.5
Total	85880	3.0	180000	5.0

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**PROPOSED PERFORMANCE OF THE FOUR REGIONS
UNDER INTENSIFICATION.
FOUR CLINICS AND GSMP/CBD PROGRAM**

EXPECTED TO BE OBTAINED IN 1996 FROM INTENSIFICATION		
REGIONS	CYPs	CCPR
BRONG AHAFO	36816	10.4
CENTRAL	34840	10.4
ASHANTI	<u>63853</u>	<u>10.4</u>
TOTAL 4 REGIONS	179296	10.4

IMPACT OF INTENSIFICATION IN TOTAL COUNTRY CCPR

	MWIFA in (.000)	CYP	CCPR
FOUR REGIONS			
WITHOUT INTENSIFICATION	1750	238465	13.6
FROM INTENSIFICATION	1750	179296	10.4
TOTAL FOUR REGIONS	1750	417761	23.8
TOTAL OTHER SIX REGIONS	1910	121534	6.4
TOTAL PROJECT	3660	539295	15.0
PPAG		180000	4.9
GRAND TOTAL PROGRAM	3660	719295	19.9

Annex H

Flow of Contraceptives and Information through the MOH Family Planning Program

Annex H

Flow of Contraceptives and Information through the MOH Family Planning Program

CONTRACEPTIVES

INFORMATION

A.I.D./W/USAID
MATRIX
INTERNATIONAL

Limited information
----->>>>--
Documents lost

MCH/FP
NATIONAL
LEVEL

ACCRA/TEMA-
Ghana Supply
Commission
CUSTOMS

Little communication
between these
two levels.
Difficult to inspect
contraceptives in customs.

Quarterly
Reports

MOH
CENTRAL
STORES

Request of contraceptives for the regional level

Nine
months supplies

MOH
REGIONAL
STORES

MCH/FP
REGIONAL
NURSE

Quarterly
Report

MCH/FP
DISTRICT
STORES
DNOs*

Six months
supplies

Monthly
Report

Four months
supplies

CLINICS

* District Nursing Offices

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Annex I

**Project Paper Objectives
Related to Contraceptive Social Marketing Project**

Annex I

Project Paper Objectives Related to Contraceptive Social Marketing Project

1. A largely self-financing commercial distribution system will be in place that can provide a reliable flow of contraceptives and family planning products throughout the established network of retail outlets.

2. An effective management supply system to strengthen and expand the contraceptive retail supply network will have been developed. There will be a planned and phased expansion of the distribution system including the necessary logistical support required to service an increasing number of retail outlets covering an expanded geographic service area. Over the life of the project this together with the MOH and NGO outlets, should result in 50 to 60 percent of the population having vastly improved access to a range of contraceptives that are reliable, affordable, and available on a regular basis.

3. Consonant with normal private sector commercial marketing and sales practice, appropriate training and information will be provided on an ongoing basis to marketing staff, retailers including pharmacists, shop keepers, chemical sellers and others who are involved in the distribution and sales network to improve sales and provide better service to clients and potential clients.

4. An important contribution of the project will be increased consumer awareness of contraceptive methods and products as the result of effective product advertising and marketing activities. The use of effective multi-media advertising coupled with carefully tailored marketing should contribute significantly to consumer motivation resulting in increased sales. A further benefit that can be anticipated from the CSM promotional activities is increased popular participation in MOH MCH/FP and other programs resulting from awareness and attitudinal changes.

5. By the end of the project, annual levels of contraceptive distribution will reach 13 percent of the women of fertile age who are married (in union). This, together with the expected 3 percent from the PVO programs, will provide an increase in contraceptive use from the 5 to 7 percent MWIFA levels in 1984 to approximately 16 percent MWIFA by 1987.

See Project Paper 02/23/85, page 7.

Annex J

**GSMP Program:
Achievements, Concerns, and Recommendations
Highlighted in the Midterm Evaluation**

Annex J

GSMP Program: Achievements, Concerns, and Recommendations Highlighted in the Midterm Evaluation

Achievements

- 1) DANAFCO has managed the program with technical assistance provided by Social Marketing for Change (SOMARC), an A.I.D. centrally funded project.
- 2) A marketing plan was developed.
- 3) A distribution system was created with at least one point of wholesale/retail distribution in each of Ghana's 10 regions.
- 4) DANAFCO personnel assigned to the GSMP were increased to include half-time program participation by the Programme Coordinator (now General Manager - Administration) and full-time program participation by the Marketing Manager (now Programme Coordinator). A research director had been hired under contract for one year by SOMARC, and an advertising manager had been hired for the company who devoted "substantial time to the program."

Concerns

- 1) Neither the Managing Director of DANAFCO nor the then Programme Coordinator had marketing expertise in their backgrounds, nor was there institutional experience in contraceptive social marketing programs still available among DANAFCO personnel. Thus DANAFCO was handicapped in providing complete leadership and management for the program.
- 2) DANAFCO had not yet acquired the skills to take full advantage of its sales data as a marketing tool.
- 3) Marketing research was not responding well to GSMP needs.
- 4) Leadership for DANAFCO's two sub-contractors (marketing research and advertising) was lacking.
- 5) Meetings with USAID and other interested parties such as MFEP had been infrequent and ad hoc. Hence contact with and knowledge of the program had not been as widespread as it should have been.

Recommendations

- 1) DANAFCO should demonstrate strong leadership and commitment to developing and managing the entire contraceptive social marketing program.
- 2) DANAFCO, with USAID support, should recruit an experienced technical adviser to increase the knowledge and skills of GSMP personnel, especially the Programme Coordinator and the Marketing Director, in marketing, program development and coordination, use of management information systems, advertising and marketing research, and program planning, scheduling and reporting.
- 3) DANAFCO, with USAID assistance should have the Programme Coordinator and the Marketing Manager visit successful CSMPs elsewhere; attend courses on social marketing, project development and management, and community-based distribution.
- 4) DANAFCO should develop a personnel plan including incentives, and should give the Marketing Manager (now Programme Coordinator) increasing responsibility for GSMP management.

- 5) **DANAFCO should review its existing marketing plan, update and modify it as needed, and use it as a regular tool.**
- 6) **DANAFCO should establish a GSMP Advisory Council to meet at least semi-annually and provide guidance, coordination and support for the GSMP.**
- 7) **DANAFCO should modify its quarterly reports to include: depot-to-retailer sales, identification of all retail outlets, and data on retailers.**

Annex K
Product Market Share

Annex K

Product Market Share

	Condoms		VFTs		Orals	
	'88	'90	'88	'90	'88	'90
GSMP*	3,491,127	3,596,600	515,698	1,581,208	347,536	443,325
MOH	60,821	806,571	348,250	683,085	126,695	428,929
PPAG	269,968	87,118	419,519	149,096	265,321	181,976
TOTAL:	3,821,916	4,490,289	1,283,467	2,413,389	739,552	1,054,230
GSMP	91%	80%	40%	66%	47%	42%
MOH	2%	17%	27%	28%	17%	41%
PPAG	7%	2%	33%	6%	36%	17%

*data taken from 1991 compilations for these years

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Annex L
Ghana Social Marketing Project (GSMP)

Annex L

Ghana Social Marketing Project (GSMP)

GSMP Distribution:

	%Pop	% Dis- trbrs	% GSMP Sales					
			Panther		Kamal		Norminest	
			'88	'90	'88	'90	'88	'90
Western	9.6	9	6	11	13	10	7	10
Central	9.0	12	1	1	1	1	2	1
G.Accra	12.0	12	60	46	19	39	25	44
Eastern	14.0	21	8	7	9	10	12	10
Volta	9.4	12	3	4	14	11	5	6
Ashanti	17.0	13	21	23	38	23	37	24
B.Ahafo	11.0	9	2	*	2	*	2	--
Northern	10.0	6	*	1	*	1	2	2
U. West	3.4	4	1	*	2	*	5	--
U. East	6.1	4	1	1	1	*	3	*
S-Depots	N.A.	N.A.	N.A.	5	N.A.	5	N.A.	3.

Distribution by DANAFCO Agent Status:

1. DANAFCO HIGHEST DISTRIBUTION COUNT DEPOTS

G.Accra	12.0	12	60	46	19	39	25	44
Ashanti	17.0	13	21	23	38	23	37	24
CUM. TOT	29.0	25		69		62		68

2. DANAFCO WHOLLY OWNED DEPOTS

Western	9.6	9	6	11	13	10	7	10
G. Accra	12.0	12	60	46	19	39	25	44
Volta	9.4	12	3	4	14	11	5	6
Ashanti	17.0	13	21	23	38	23	37	24
CUM.TOT.	48.0	46		84		83		84

3. DANAFCO AGENT DEPOTS (on 5% Commission)

Eastern	14.0	21	8	7	9	10	12	10
Northern	10.0	6	*	1	*	1	2	2
CUM.TOT.	24.0	27		8		11		12

4. DANAFCO SUB-AGENTS (on 2 1/2% Commission)

Central	9.0	12	1	1	1	1	2	1
B.Ahafo	11.0	9	2	*	2	*	2	--
U.West	3.4	4	1	*	2	*	5	--
U.East	6.1	4	1	1	1	*	3	*
CUM.TOT.	29.5	29		2		1		1

* Less than 1/2 of 1%

DANAFCO RELATIONSHIP:	% of Pop.	% of Distrbrs	1990 % of Sales		
			Panther	Kamal	Norminest
DEPOT REGIONS	48.0	46	84	83	84
AGENT REGIONS	24.0	27	8	11	12
SUB-DEPOT REGIONS	29.5	29	2	1	1
(Sub-Depots)*	N.A.	N.A.	5	5	3
TOTAL**	101.5	102	99	100	100

* Reported separately by DANAFCO; included to represent total sales.

** Percentages do not add precisely to 100% due to rounding.

DANAFCO Distribution Network

1. Greater Accra: DANAFCO ACCRA DEPOT
2. Volta Region: Hohoe DANAFCO DEPOT;
Ho (regional capital) sub-depot;
Denu sub-depot,
Jasikan sub-depot;
(Sogakofe sub-depot experiment)
(Keta sub-depot experiment)
3. Eastern Reg: Korforidua (regional capital) DANAFCO Agent
Asamankese sub-depot
Oda sub-depot
Nkawkaw sub-depot
Somanya sub-depot
Asesewa sub-depot
4. Central Reg: (Cape Coast Reg. Cap. - terminated, covered by Takoradi)
Ajumaku sub-depot
Swerdru sub-depot (2/91 experiment)
(5% commission)
5. Western Reg: Takoradi (covers capital) DANAFCO DEPOT
Elubo sub-depot
Prestea sub-depot

(Half Assini sub-depot - terminated)

6. Ashanti Reg: Kumasi (regional capital) DANAFCO DEPOT
Konongo sub-depot
Obuasi sub-depot
Effiduasi sub-depot (no reports received for several months)
7. Brong-Ahafo: (Sunyani; regional cap. served by Kumasi)
(Techiman - terminated; Kumasi covers)
(Atebubu - terminated)
(Dormaa-Ahkenroo: slow reporting; Kumasi covers)
8. Northern: Tamale (regional cap.) DANAFCO Agent
9. Upper West: Wa (regional cap.) sub-depot
10. Upper East: Bolgatanga (regional cap.) sub-depot

OUTLET DEFINITIONS

Wholly owned depots (4) are housed in DANAFCO-owned warehouses, and managed by DANAFCO employees.

Agents (2) operate out of leased space, distribute only DANAFCO products, and work on a 2.5% commission basis.

Sub-depots (15, plus 3 experiments) are effectively manufacturers' representatives. They distribute a variety of manufacturers' products, in addition to DANAFCO and GSMP products. Their commission on GSMP products is 2 1/2%.

Population Groups Reached

The Summary of Findings of the MSRI 1990 GSMP User Intercept Study (in which consumers were intercepted after having been observed purchasing a GSMP product at a pharmacy or chemical seller) offers the following profiles of GSMP users:

Panther: "The typical Panther user is aged between 26 and 40 years with some secondary education, lives in union with 2 children and belonged to the CD SES group."

Kamal: "The typical Kamal user intercepted is aged between 26-35 years, completed primary education, lives in union with 2 children and belongs to the CD SES group."

Norminest: "The typical Norminest user intercepted is aged between 26 - 36 years, had some secondary or completed secondary school, lives in union with 2 children and belongs to the D SES group, although a quarter are also in class A/B."

GSMP PRODUCT PRICE INCREASES: 1986 - 1991

	initial*	2/89*	1 /91*	11/91*	% increase
Panther wholesale	2.10	5.00	8.00	14.00	566%
Panther retail	2.50	6.00	10.00	20.00	700%
Return to project	.32	.76	1.03	7.97	2390%
Kamal wholesale	16.00	30.00	45.00	83.00	419%
Kamal retail	20.00	40.00	55.00	105.00	425%
Return to project	.35	.66	.89	56.00	15900%
Norminest wholesale	50.00	85.00	100.00	100.00	100%
Norminest retail	60.00	100.00	120.00	100.00	100%
Return to project	4.00	6.80	8.18	8.18	104%
Secure wholesale	N.A.	N.A.	N.A.	83.00	N.A.
Secure retail	N.A.	N.A.	N.A.	105.00	N.A.
Return to project	N.A.	N.A.	N.A.	54.00	N.A.
Protector wholesale	N.A.	N.A.	N.A.	35.00	N.A.
Protector retail	N.A.	N.A.	N.A.	45.00	N.A.
Return to project	N.A.	N.A.	N.A.	25.17	N.A.

* Panther and Protector single units; Kamal 8-packs; Norminest and Secure single cycles.

MARKET RESEARCH IMPLEMENTED BY MSRI 1990-1991

1. Focus groups on Kamal, Norminest, Norquest (Secure), Panther, and Protector, April, 1990. This study was designed to explore knowledge, attitudes and behavior of men and women, assess the image of GSMP products, and test a range of new package designs and brand names. The study was conducted in Accra, Kumasi, and Takoradi.

2. Consumer intercept among GSMP product users, conducted in Accra, Kumasi, Takoradi, and Tema, in May, 1990. This was a small-scale quantitative study designed to learn about the characteristics of GSMP product users.

3. Focus groups on Kamal and Secure pack designs, January, 1991. The sessions were conducted among women 18 -34 in Accra.

4. Small-scale one-on-one interviews on Protector pack designs were conducted among men in March, 1991, in Accra .

5. A small-scale one-on-one intercept study was conducted as a Secure/Kamal Pre-Advertising test in October, 1991.

6. Pan-African Protector Baseline quantitative study, conducted in October, 1991 in Accra, Kumasi, and Takoradi.

7. Sales analysis of the Market Women test market in Accra; analysis due December, 1991.