

**EVALUATION OF THE  
USAID/MALI COMPONENT OF THE  
FAMILY PLANNING LOGISTICS  
MANAGEMENT (FPLM) PROJECT**

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by

Gerald D. Moore

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Edited and Produced by

Population Technical Assistance Project  
1611 North Kent Street, Suite 508  
Arlington, VA 22209 USA  
Phone: 703/247-8630  
Fax: 703/247-8640

Project No. 936-3024

Email: [POPTech@BHM.Com](mailto:POPTech@BHM.Com)



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## LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
AMPPF	Association pour la protection et promotion de la Famille/Planned Parenthood Association of Mali
CBD	Community-Based Distribution Project
CHPS	Community Health and Population Services Project
CPR	Contraceptive Prevalence Rate
CPT/TAC	Contraceptive Procurement Tables
COCOPLAN	Contraceptive Commodity Planning
CPSD	Commodities and Program Support Division (USAID Office of Population)
CYP	Couple Years of Protection
DNSP	National Directorate of Public Health/Direction Nationale pour la Santé Publique
DSFC	Division of Family and Community Health/ Division de la Santé Familiale et Communautaire
EDP	Essential Drugs Program
FP	Family Planning
FPLM	Family Planning Logistics Management/ Gestion de Logistique de la Planification Familiale
FY	Fiscal Year
Generics/DCI	Medicaments de Denomination Internationale Commune
GIF	Interinstitutional Training Group/Groupe Interinstitutionnel de Formation
GRM	Government of Mali
IFAHS	Integrated Family Health Services Project
IPPF	International Planned Parenthood Federation
JSI	John Snow Inc.
LMIS	Logistics Management Information System
LOE	Level of Effort
MAF	Missionary Aviation Fellowship
MCH	Maternal and Child Health
MSSPA	Ministry of Health Solidarity and of the Aged/ Ministère de la Santé, de la Solidarite et des Personnes Agées
NGO/ONG	Non-Governmental Organization
PNLS	National AIDS Prevention Program/Programme National pour la Lutte contre le SIDA
PPM	Pharmacie Populaire du Mali
PSPHR	Population, Health and Rural Hydrology Project/ Projet pour la Sante, la Population et de la Hydraulique Rurale
RA	Resident Adviser, FPLM project
RLA	Regional Logistics Adviser, FPLM Project
SDP	Service Delivery Point
SOMARC	Social Marketing of Contraceptives Project
STS	Quarterly Stock and Utilisation Reports/ Situation Trimestrieeel de Stock

UNFPA/FNUAP  
USAID  
WHO/OMS  
WRA

United Nations Population Fund  
United States Agency for International Development  
World Health Organization/ Organisation Mondiale de la Santé  
Women of Reproductive Age

## PROJECT IDENTIFICATION DATA

1. **Project Title:** USAID/Mali Component of the Family Planning Logistics Management (FPLM) Project
2. **Country:** Mali
3. **Project Number:** 936-3038
4. **Project Dates:**
  - Agreement Signed: March 8, 1993
  - Most Recent Agreement Signed: March 8, 1993
  - End Date: August 31, 1994 (a no-cost extension through April 1995 is anticipated).
5. **Project Funding:**
  - Authorized LOP Funding: \$249,717.00
6. **Mode of Implementation:** Buy-in
7. **Responsible USAID Officials:**
  - Mission Director: Charles Johhson
  - Project Officer: Lucy Mize
8. **Previous Evaluation:** None



## EXECUTIVE SUMMARY

The Family Planning Logistics Management buy-in has, since its start in March 1993, made considerable achievements in

- Developing the Logistics Management Information System
- Training field personnel (region and district) in Family Planning (FP) logistics management
- Tracking contraceptive procurement and supplies through management of the contraceptive procurement tables (CPTs)
- Coordinating with other FP programs and donor agencies
- Assessing the storage and distribution (including transportation) needs of the current program, and its future expansion

As a consequence of the above, there is an observed improvement in FP logistics management skills and, in most cases, stock levels of the most-used contraceptives, at least down to the district level. The program is therefore perceived to be making a significant contribution to the overall objective of the national family planning program to make contraceptives of the right type and quality always available to existing and potential FP acceptors.

However, there are indications that there are some weaknesses in the current system that still need attention during the life of the current buy-in and beyond.

### **Project Management**

Family planning logistics management of the DSFC (Division of Family and Community Health) needs to become stronger in the area of **field supervision**. Until the logistics management system is fully established as an integral part of the maternal and child health (MCH)/FP program, with regular monitoring and supervision, DSFC staff should visit regional health directorates and FP clinics at regional and district levels on a regular basis. It is recommended that each region should be visited at least once a quarter.

These visits will help reinforce the training of staff in good FP logistics management, identify weaknesses and rectify them, monitor the operations of the system, and take speedy action to resolve any problems.

One of the main objectives of this supervision from the central level will be to train and motivate regional and district health teams to carry out effective supervision from their levels and help ensure the smooth operation of FP logistics management.

The FPLM buy-in would be a suitable "vehicle" through which to strengthen the DSFC's level of field supervision; it is recommended that the DSFC's supervisor(s) work closely with the logistics management resident adviser, as do the training and supplies specialists, and produce regular reports for the resident adviser and DSFC management which can be used for strengthening the system as well as for management information.

If present availability of staff time is insufficient, perhaps other DSFC staff could be re-assigned to this function.

It is felt that FP logistics management staff, particularly in this crucial stage of the family planning program, should operate more as a team (coordinator, training specialist, supplies specialist, field supervisor) than at present, with the coordinator reporting directly to the head of FP in the DSFC.

Expertise now residing mainly in the resident adviser, in such areas as CPTs, coordination and logistics management information systems, needs to be shared with other staff. Each member should have expertise in all aspects of FPLM work, so that effective management can continue even if one member is absent.

Coordination with other FP projects and programs should be strengthened, so that the DSFC is fully aware of FP operations in the country, and is in a better position to advise on policy, requirements, and strategies.

FPLM management should have control over its own operations, including budget and means of transportation. For larger-scale operations, such as training programs, it should have clear and rapid access to funding sources; however, it should submit plans of operation and requests for such funds through the appropriate channels well in advance.

It should also, in due time, and after the necessary controls are in place, be able to allocate funds for training and supervision operations more directly to the regions.

Though FP logistics management staff may benefit from being organized as a team, receiving external technical and financial assistance, it should not operate as a separate or vertical unit within the DSFC but rather as an integral part of total MCH/FP management.

## **Training**

The FP training component has been further developed during the time of the buy-in, however there is a pressing need to update the training at regional and district levels and to accomplish the training of personnel at the arrondissement level.

Training in FP logistics should become integrated into the standard and regular health training curricula as part of the DSFC's continuing education program. This should continue throughout the present buy-in and into the future program period.

The training materials are practical and effective; however, they may need some refinement and updating at regular intervals, i.e., annually, and technical assistance may be required to accomplish this.

Some suggestions are made in the main report which might improve certain aspects of the training.

### **Logistics Management Information System (LMIS)**

The current logistics management information system needs revision and expansion, particularly relating to the information that is fed back to the regions and districts, which at present does not seem of great utility. More relevant data could be given, such as demographic updates, growth in contraceptive prevalence, changes in preferences, method mixes, and use patterns, region by region. However, information fed back to the regions and districts depends greatly upon the information sent in to the centre at the DSFC.

Current information flows to the central level are often slow or inadequate; there should be a more effective method of obtaining field reports on time. The Situation Trimestrielle des Stocks (STSs), which are used under the system as order mechanisms, are subject to delays and sometimes contribute to out-of-stock situations unless dispatched and acted upon promptly.

A new health management information form is now being tested under the coordination of the Population, Health and Rural Hydrology Project (PSPHR). It contains space for entering considerable FP information. When implemented early in 1995, this report form is likely to improve the level and quality of information coming from the field.

However, it will not replace the present report forms in use, specifically for FP logistics management, but rather supplement them. In this case, there may be no need for any changes to be made in the present FP logistics forms, for the time being at least. However, one of the aims of FP logistics training and supervision follow-up should be to encourage regional and district level health management in analysis of information at those levels.

Automation of the LMIS would bring improvements in the speed of information flows and therefore improve the efficiency of the logistics system. However, first, the type of information needs to be reviewed and the cost/benefits of automation studied. This could be done in a future project period or through The Community Health and Population Services (CHPS) Project, which has a long-term (at least two years) management information development component.

### **Storage and Distribution**

Storage conditions at region and district levels are often below standard and may contribute to deterioration of stocks. Some basic and inexpensive measures can be taken (e.g., fans, cleanliness, and shelving) to improve the situation until new structures are completed in line with the assessment of a DSFC/FPLM team from January/February 1994.

Distribution is a problem area; there are several out-of-stock situations at regional and district levels which is discouraging FP service providers and potential acceptors. The main reasons are believed to be not lack of transportation but poor transportation management and the fact that FP may not yet be fully integrated in the health supplies system.

Also, the fact that regions and districts must seek their supplies, rather than having them delivered to them, plus the shortage of funds for fuel and oil, may be contributing to the problem.

A truck for the central level and light vehicles for the regions has been proposed to be made available by the DSFC/FPLM mission in January/February 1994. The evaluation consultant finds that neither a truck nor light vehicles would provide the optimal solution, and may be the most costly of all. A distribution arrangement with an organization such as the Pharmacie Populaire du Mali (PPM) for transport to the regions would seem to offer certain advantages and be the most cost-effective.

However, if it is decided to purchase a truck for the National Directorate of Public Health (DNSP), which could be used for transportation of FP supplies to the regions on behalf of and in close coordination with DSFC FP logistics management on a regular, guaranteed basis, then this would be a suitable alternative.

Sufficient light vehicles are believed to be in place or on order for the regional level. What is required is sufficient managerial effort and funds for fuel, travel, etc., rather than more vehicles, and adequate FP supervision by regional and district health managers.

### **Institutionalization and Integration, including Sustainability**

Of primary importance is the full institutionalization of the FP logistics management system within the DSFC in the Ministry of Health, Solidarity and of the Aged's (MSSPA's) structures.

Although the project has already achieved considerable progress in institutionalizing systems both at the central and field levels, there needs to be a more intensified transfer of technology and skills from the project advisers to local personnel. For example, preparation of CPTs should be seen not just as a FPLM project component, but one which is seen as a MSSPA/DSFC procedure and which could be also adapted and used for other medical supply projects.

Through The FPLM Project, FP logistics management should be an integral part of the DSFC's structures, using the same systems of management information and supply channels. This process will take time, however, and it is unlikely that integration will be achieved during the life of the current buy-in. Continued external technical assistance may be necessary for at least the next one to three years.

Good **coordination** with other FP programs and agencies, such as the Planned Parenthood Association of Mali (AMPPF), SOMARC, and CBD, as well as with major donors, such as UNFPA, is extremely important to ensure that there is mutual synergy and no duplication and that delivery schedules are respected and feedback received.

It is likely that with the improvement in the MSSPA/DSFC FP logistics system AMPPF's role as a provider of FP commodities may be reduced. Its limited stocks in its antennes are moving very slowly. Its future role appears to lie more in the private sector, particularly sensitization, education, and information.

### **Essential Drugs Program**

The Essential Drugs Program (EDP) is still in its early stages and its long-term viability is not yet clear. There would not appear to be major benefits in combining the FP logistics management system with that of essential drugs, for the time being at least, apart from possible advantages to be gained in storage and distribution.

There would not appear to be a conflict in providing FP items free when essential drugs are being sold. The objectives of the two programs are somewhat different: the national FP program aims to provide access, availability, and usage as widely as possible to even the poorest, and FP supplies are provided free by external agencies to help in this objective; essential drugs are intended to be used only where necessary and as rationally as possible, and patient charges will help cut down over- and irrational usage. Governments must exert some charges, as a completely free essential drugs system is beyond the financing powers of even many developed countries.

However, the experience of the essential drugs program may provide useful data for a possible later introduction of FP charges, should this be decided upon by the national authorities.

### **Sustainability and Cost Recovery**

The issue of contraceptive program sustainability, in terms of cost recovery, in the public sector still has to be addressed. As social marketing, AIDS prevention, and community-based distribution programs grow, with contraceptives being sold at "social" prices, the public will gradually become used to charges for contraceptives. At present, with adequate supplies from USAID, UNFPA, etc., it may be premature and inhibiting to poorer acceptors to levy charges in government FP clinics, though this is already being done in some regions, e.g., Mopti.

However, as time goes on, the issue of long-term sustainability of contraceptives must be addressed, and a strategy formulated. The project could study this issue in 1995.

### **Future Planning**

The current FPLM buy-in is due to close by the end of April 1995. Though much has been achieved in its short life since August 1993 (effective starting date), it is suggested that the national public sector FP logistics system is still in a too fragile and embryonic stage to take away support and expect it to run on its own.

Financial and technical support will still be necessary through and beyond April 1995, particularly, but not only, in the areas of contraceptive procurement tables, management information system

development, coordination and training. Also, the area of storage and distribution, including a new, better system of transportation, needs to be followed up and implemented.

For these reasons, this consultant recommends that USAID and the MSSPA/DSFC consider seriously the extension of FPLM support beyond the lifetime of the current project.

## SUMMARY OF RECOMMENDATIONS

1. The Mali FPLM buy-in is progressing well and, despite the late start, on the way to achieving most objectives. However, there needs to be a faster and more intensive transfer of skills from the resident adviser to other staff in the Division of Family and Community Health (DSFC) where the project is located.

It is recommended that the FPLM project work with others in the DSFC more as a team with shared skills, and not focus only on one resident adviser, though the resident adviser should act as the coordinator of the team.

2. There should be increased supervision in the field. This means an increased supervision function for the logistics management team in the DSFC team. This should be achieved by defining and directing responsibilities of existing DSFC supervision staff toward FP logistics management. If sufficient staff time is not available, other DSFC staff should be reassigned to this function.
3. FPLM management should have better and easier access to project operational funds and transportation; it should, however, submit plans and budget well in advance and develop targeted strategic plans rather than operating on an *ad hoc* basis.
4. Training must remain a priority of the project until the level of FP management in the regions, districts, and arrondissement reaches acceptable levels. Arrondissement training must be completed this year and refresher follow-ups of regional and district health/FP staff in the first quarter of 1995. Training in FP logistics should be integrated as soon as possible into the national health training curricula.
5. The logistics management information system needs to be refined and further developed to give more relevant information. However, it should not become more burdensome on FP staff.
6. Coordination by FPLM project management with other agencies and organizations active in the FP field should be strengthened. The FPLM Project should develop the DSFC's coordination function for achieving effective, timely, and synergistic support to the national FP program from aid agencies, donors, NGOs, and other interested parties, including private institutions and groups.
7. Though transportation remains a problem and is contributing to some out-of-stock situations, it is not recommended to purchase a truck specifically for FP logistics. This would not be cost-effective. Nor is it recommended to purchase light vehicles for the regions; they have sufficient transportation already and can hardly manage what they have. However, if a truck is purchased for the DNSP, its use as transporter of FP products would strengthen FP distribution.
8. It is not recommended that USAID/Mali become more involved in the preparation of contraceptive procurement tables (CPTs), but should retain a critical review role, as well as one of tracking supplies. To increase efficiency in this function, some training in FP may be considered for USAID staff.

9. It is not recommended that the FP logistics system become closely linked with the Essential Drugs Program, at this stage at least, except possibly in the areas of transport and distribution where some advantages may be gained. It is also not recommended, for the time being at least, that contraceptives be charged for in government health/FP centers and clinics, though the Essential Drugs Program as well as other FP services (e.g., SOMARC, CBD) may sensitize the population to paying for services and essential drugs/FP items and lead to re-examination of this question at a later stage.
  
10. It is recommended that, in view of the good progress made in The FPLM Project, as well as the critical stage of the national family planning program and its declared objectives (e.g., to reach 11 percent contraceptive prevalence rate by 1997) and the activities which still have to take place to establish and institutionalize FP logistics in the national health system, the FPLM project should continue, with external technical assistance, for at least another one to two years after the life of the current buy-in. External technical assistance may, however, be reduced or adapted to changing needs.

# **1. INTRODUCTION**

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## **1.1 Background**

In 1993, USAID/Mali executed a buy-in to the Office of Population's Family Planning Logistics Management (FPLM) Project to provide technical assistance in contraceptive logistics management to the Division of Family and Community Health (DSFC) of the Ministry of Health, Solidarity and of the Aged (MSSPA) and other family planning organizations and groups in Mali. This technical assistance has been primarily focused on the design and development of an effective national family planning logistics system, including estimation of contraceptive needs and training of key health personnel in family planning (FP) logistics management. The Mali FPLM activity was most recently extended by a FY93 buy-in to the project. This funding will continue the project through April 1995.

## **1.2 National Family Planning Target**

The stated aim of the Government of Mali (GRM) is to increase the current contraceptive prevalence rate (CPR) of currently around 3 percent to 11 percent of women of reproductive age (WRA) by the year 1997. In 1990, out of a population of 9.2 million, there were estimated to be 4.7 million females out of which 44.3 percent or 2.1 million were in the reproductive age group (WHO, World Bank estimates).

At an annual average population growth rate of 3 percent, by the year 1997, there will be approximately 3.2 million women in the reproductive age group. With a target of 11 percent modern contraceptive usage, this means that by 1997 approximately 280,000 more women will need to be provided with access to affordable and otherwise acceptable contraception methods e.g., pills, spermicides, intrauterine devices (IUDs), injectables, over the 70,000 that are presently estimated to use them regularly.

As a comparison, it is estimated by the World Health Organization (WHO) that by the year 2000 some 27 percent of fertile women in Africa will be using modern methods of contraception. (See Appendix B.)

The target set by the Government of Mali cannot be said, therefore, to be unrealistic; however, because of the relatively low base, major efforts and resource allocations will have to continue to be made and even intensified in family planning by all parties, in the public as well as the private sector (non-governmental organizations [NGOs]), in the years to 1997 and thereafter.

The FPLM assistance provided to Mali by USAID is therefore of critical importance to the achievement of this national goal.

### **1.3 USAID FP Commodities Assistance**

In addition to technical assistance, contraceptives of most need (pills, spermicides, condoms, IUDs) have been supplied by USAID in increasing quantities since 1990. These have been provided to the MSSPA/DSFC as well as to service providers and agencies in the private sector, such as the Planned Parenthood Association of Mali (AMPPF), National AIDS Prevention Program (PNLS), Social Marketing of Contraceptives (SOMARC) Project, Community-Based Distribution Program (CBD), and other NGOs. These supplies have been managed under the evolving FP logistics management system (see Appendix C).

The technical assistance provided by The FPLM Project has played, therefore, a crucial part in the contraceptive supply program and has included development and application of computer programs for needs forecasting and supplies tracking (NEWCPT, COCOPLAN, NEWVERN, etc.) which have provided the DSFC and USAID/Mali with appropriate tools with which to manage contraceptive ordering and shipping.

## **2. FAMILY PLANNING LOGISTICS MANAGEMENT: OVERALL PURPOSE**

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The stated overall purpose of USAID FP logistics management technical assistance has been and is to assist the MSSPA in establishing a contraceptive logistics system which ensures the availability of contraceptive commodities at maternal and child health (MCH)/family planning clinics and develops the capacity to manage those contraceptive supplies.

### **2.1 Technical Activities under FPLM II**

Under the larger FPLM Project, under which assistance has been provided to Mali among other countries since 1986 and which is now approaching the end of the second phase (FPLM II), there have been seven major areas of technical activity (FPLM Progress Report, January–June 1993):

1. Technical assistance to family planning and AIDS control programs in developing countries, in the areas of logistics management, logistics management information systems (LMIS), quality assurance, local production and local procurement, and contraceptive forecasting
2. Training for developing-country FP and AIDS control program staff
3. Special studies and promotion of logistics issues to foster logistics system improvements
4. Development and monitoring of contraceptive requirements and AIDS condom estimates for USAID-assisted programs
5. Assistance to the Commodities and Program Support Division (CPSD), USAID Office of Population/Washington in central commodity procurement and management
6. Management, enhancement, and institutionalization of the Population Projects Database
7. Appropriate collaboration with other donors and USAID Cooperating Agencies in the pursuit of FPLM activities



### **3. REQUEST FOR INCREASED TECHNICAL ASSISTANCE: THE BUY-IN**

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In 1992, USAID/Mali requested increased technical assistance under the FPLM program, particularly in the areas of training in FP logistics management, expansion and refinement of the logistics management system, improvement and institutionalization of contraceptive distribution and data collection, actions needed to improve storage conditions and distribution systems throughout the public sector pipeline, and transfer of skills in forecasting and analyzing commodity needs.

#### **3.1 Expected Outcomes and Activities of the Buy-in**

It is worthwhile here to recapitulate the expected outcomes and activities of the FPLM buy-in, which are as follows (USAID/Mali, Delivery Order No. 05, dated 24 March 1993):

1. Improved storage and distribution systems throughout the public sector pipeline
2. A Contraceptive Logistics Procedure Manual for each level of the pipeline
3. A reliable flow of logistics data to managers at the district, regional, and central level for the monitoring of supply status and the preparation of annual forecasts
4. System for the collection and aggregation of logistics data for analysis at the central level
5. Fully trained MSSPA personnel, particularly in the DSFC who are able to implement a contraceptive logistics system
6. Training curricula and skilled trainers so that logistics management skills can be imparted to new staff without outside assistance.

It can be seen, therefore, that the activities and objectives planned under the FPLM buy-in represent in several respects an intensification and focusing of those FPLM services which had specific relevance/pertinence to program requirements in Mali. Considerable inputs were made to the Mali family planning program before the start of the buy-in, under FPLM II and other projects, such as Integrated Family Health Services (IFAHS), which facilitated and strengthened its impact (e.g., assessment of needs, development of training curricula, and training of key personnel).

However, the purpose of the present evaluation is to assess only the progress and impact on the national family planning program of the buy-in. An evaluation of the larger FPLM II project is presently nearing completion under a separate program.

### **3.2 Present Status of the FPLM Buy-in**

The original start of the buy-in was scheduled for March 1993 and its end in August 1994, a time span of 18 months. However, because of certain start-up delays, main activities only began by mid-year 1993, when a local resident adviser, Mme. Traore, was hired and became operative. The project has thus, at this stage, only effectively completed about nine months of activities, and USAID/Mali and DSFC have requested two extensions of the project period, one to December 1994, and a further one to the end of April 1995. As there will be no additional budgetary implications, these no-cost extensions are expected to be approved by USAID/Washington.

The buy-in was therefore at its midpoint at the time of this evaluation. Activities to be undertaken from June 1994 through to the end of April 1995 have already been planned following the visit of the FPLM regional adviser in April 1994 (see below).

## **4. EVALUATION: METHOD OF WORK**

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### **4.1 Evaluation Activities**

The evaluation of the FPLM buy-in for Mali was assigned to The POPTECH Project in Washington, D.C., and Gerald Moore, as consultant to POPTECH, carried out the evaluation as a one-man team.

The evaluation was undertaken in the period May 23–June 25 1994. Of this time span, two days were spent with POPTECH in Washington for initial briefing and administrative arrangements, including discussions with Dr. John Crowley, USAID Office of Population. One day was spent with John Snow, Inc. (JSI), Washington, the contractor agency for the buy-in (as well as the main contractor for the FPLM II project), and one day en route to Mali with the FPLM regional logistics adviser (RLA) in Dakar, Senegal, for more briefing related specifically to project activities.

The rest of the evaluation time span was spent in Mali, according to a program established by the USAID Mission and the DSFC, under which 10 days were spent on field visits to four regions and the District of Bamako and some 18 days in Bamako itself.

#### *4.1.1 Field Visits*

The field visits enabled the consultant to follow the chain of logistics management down from the DSFC center in Bamako through to the level of the arrondissement (rural health post) to observe the strengths and weaknesses in the present system first hand and to have detailed discussions with health management personnel. On these field visits the consultant was ably guided by a representative from the DSFC, Mr. M. Sangare, manager of the Statistics, Evaluation, and Research Department, and Mr. S. Traore, social sector project officer, Population, Health and Rural Hydrology Project (PSPHR).

#### *4.1.2 Primary In-country Contacts*

During the time in-country, the activities of the consultant were guided and supported by the management of the Division of Family and Community Health which is, as part of the Ministry of Health, the primary agency for the buy-in assistance; The Population, Health and Rural Hydrology Project, which provides the coordination and funding mechanisms to the project; the management of the Community Health and Population Services (CHPS) project, from which the funds for the buy-in are sourced, as well as by the USAID Mission in Bamako.

Though certain activities and visits were considered essential to the work of the evaluation, and which were followed specifically, the consultant was provided with the freedom and the means (e.g., transport) to carry out whatever activities and visits were thought by him necessary to undertake best the assignment. This "freedom of action" was much appreciated and enabled an evaluation to be made as objectively and as comprehensively as possible.

## 4.2 Scope of Work of Evaluation

The Scope of Work for the evaluation was comprehensive and well-defined (see Appendix A). It focused attention on four key areas:

- Project management
- Project performance
- Priority tasks for FPLM
- New directions

## 4.3 Aims of the Evaluation

The principle aims of the evaluation were to see how well and how far the original activities planned under the buy-in had been carried out, what impact these had had, were having, and could be expected to have on the effective logistics management of the national family planning program; whether further activities planned under the buy-in to the end of the planned second extension (April 1995) could be reasonably expected to contribute to the achievement of the overall buy-in objectives or whether other activities might be preferable; and whether, at the end of the second prolongation, there might be a need for continuation of ongoing activities or new activities in order to ensure the firm establishment and future survival of effective family planning logistics in Mali, which in themselves are critical for the availability and accessibility of family planning to the population of the country.

## 4.4 Indicators

The overall efficiency and impact of any logistics management system can be assessed by measuring against the five rights (Handbook of Indicators for Family Planning Programs, The EVALUATION Project): How well the system ensures the **Right quantity of the Right quality goods sent to the Right place at the Right time at the Right cost.**

In particular, any logistics management evaluation should look at the extent of

- Pipeline wastage
- Storage capacity meeting acceptable standards
- Frequency of stock-outs
- Service delivery points (SDPs) stocked according to plan
- Key personnel trained in contraceptive logistics and able to operate the system efficiently
- Composite indicators for commodities and logistics

## 5. FPLM BUY-IN ACTIVITIES

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(Document provided by FPLM regional adviser, Dakar [see Appendix E].)

### 5.1 Completed, Current, and Planned Activities

The activities said to be completed so far (April 1993 – June 1994) are the following:

- Employment of resident adviser within the DSFC
- Training and follow-up of regional and district FP providers in logistics management
- Preparation and completion of contraceptive procurement tables for 1993 and 1994
- Logistics management course (8 days) for key officials and trainers at MSSPA, USAID/Mali, and other local family planning organizations
- Training in the use of LMIS data for management purposes to officials of the DSFC
- New training curricula developed for arrondissement level
- Assessment of the contraceptive transport and storage situation with recommendations for improvement

According to documents, reports, and discussions with key personnel at the DSFC, PSPHR, and FPLM management in Washington, Dakar, and Bamako, these activities appear to have been satisfactorily completed within the planned time frame.

Forthcoming activities planned under the buy-in under original list of activities are the following (see Appendix E):

- Stock management training for the arrondissement level (July–September 1994)
- Mid-year review of Contraceptive Procurement Tables (CPTs) (October 1994)
- Follow-up of district and arrondissement level training (January–March 1995)
- Workshops in uses of logistics data and forecasting (date not specified)

The following additional activities are planned for the buy-in through the remaining life of the project period (expected to be April 1995)(see Appendix E):

- Compiling quarterly data from STSs (quarterly stock and utilization reports) and publishing of retro-information
- Organizing and chairing quarterly coordination meetings with managers from each of the recipients of USAID-supplied contraceptives to collect distribution and stock level data and discuss logistics management issues
- Following up with recommendations for improvements in transportation and warehousing
- Monitoring the Pharmacie Populaire of Mali (PPM)/Social Marketing of Contraceptives Project (SOMARC)

- Monitoring the start-up of the new Community Based Distribution Program (CBD) and ensuring the information system responds to information needs for CPT preparation
- Monitoring PNLs progress, in particular monitoring the impact of free distribution of condoms on price and sales volume of contraceptives sold through CBD and social marketing programs
- Monitoring supply to NGOs
- Monitoring the process of moving toward cost-recovery measures, e.g., in the case of contraceptives, and studying possible linkages with the national essential drugs program
- Preparing 1995 CPTs

## **5.2 Principle Questions Relating to Activities**

The principle questions to be answered are 1) how far have the already accomplished activities satisfied the objectives as described in the buy-in Delivery Order, with the overall goal of assisting the MSSPA in establishing and running an efficient FP logistics system and 2) whether the planned activities for the rest of the expected project life are well focused on management areas of greatest need and expected to contribute further to the strengthening and sustainability of the system as well as making the best use of the unspent funds.

## **5.3 Five Basic Areas of Activity to be Evaluated**

To answer these questions, it is proposed that the activities to be evaluated be grouped into five basic areas of logistics management and their perceived and likely impact on the achievement of the main goal of the buy-in and of the national family planning program in general be assessed, i.e., to improve the accessibility and availability of contraceptives to the nation in line with national needs.

In short, is the buy-in helping to make family planning commodities easily available? Are acceptors increasing? Are contraceptives moving out of the storerooms? Is the system becoming institutionalized, integrated, and sustainable? When the buy-in ends, will the system continue? Or is more support necessary?

The five basic areas or components of logistics management covered under the buy-in's expected outcomes and activities can be stated as follows:

1. Project management, including coordination and supervision
2. Training, including the development of curricula and materials
3. Logistics management information system and preparation of CPTs
4. Storage and distribution, including transportation
5. Institutionalization and integration, including sustainability and possible coordination with other FP programs

Under these components, the points elaborated under Section C (evaluation questions) of the evaluation Scope of Work will be addressed (see Appendix A).



## **6. PROJECT MANAGEMENT**

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### **6.1 Project Staff**

The management of the FPLM buy-in consists of a resident adviser, presently Mme. Aoua Traore, based at the DSFC in Bamako, supported by a regional logistics adviser, presently Mr. Tim Rosche, based in Dakar, Senegal, management, logistics, and administrative specialists from JSI/FPLM headquarters in Washington, and by project officers at the USAID Mission in Bamako, presently Ms. Carol Hart and Ms. Lucy Mize.

Under the buy-in Scope of Work, it was clear that the resident adviser would be the focal point for the management of the project and that much of the project's success or failure would depend upon that position. Fortunately, the present incumbent Mme. Traore had much experience in family planning training before assuming her present position in August 1993, having been training adviser in the Integrated Family Health Services Project (IFAHS) between 1990–1992 and before that training supervisor and advisor in the Division of Family Health (1982–1990).

The buy-in resident adviser was, therefore, able to enter into her new position without needing much reorientation, which was definitely a positive factor in the quick start-up to the project once underway, particularly in the training aspects.

However, in taking over her present responsibilities, Mme. Traore had to become proficient in the operation of computerized FP information systems, including preparation of contraceptive procurement tables. Training was provided to her at JSI offices in Washington in early September 1993 and later through visits to Mali by the FPLM regional adviser in Dakar, Mr. Tim Rosche. This has undoubtedly strengthened the management of the project.

Back-up to the resident adviser in areas such as training, storage, transportation, and assessment of FP commodity needs (CPTs) has been provided from the Regional Office in Dakar on three occasions since the start of the buy-in and from Washington twice. One, possibly two, more visits from the Regional Office are planned for the rest of the expected buy-in period specifically to review the 1994 CPTs and to prepare those for 1995.

### **6.2 Increased Consumption of Contraceptives**

The indications are that the buy-in is already achieving success in its main objective of improving access to contraceptives in public health facilities. A summary of estimated consumption (Appendix F) shows a considerable increase of all contraceptive types between 1993 and 1994. 1995 provisional estimates made on the basis of 1994 CPTs show a further healthy increase of the major types, particularly condoms and the combined pill. It is likely that injectables would show a larger increase if this form had been in sufficient stock over the past two years.

### **6.3 Level of Effort**

An analysis of Level of Effort (LOE) by JSI Washington (Review Document JSI/FPLM Responses to Mali Evaluation Questions, May 24, 1994) shows that during the first quarter of 1994, the percentage LOE given by the resident adviser was 78 percent, that of short-term technical assistance (Regional Office Dakar) 6 percent, and management backstopping (JSI Washington) 16 percent. This would appear to be a healthy division of Level of Effort in terms of local management, transfer of technology, and institutionalization of the system. As it comfortably exceeds the 130 out of 198 work days (66 percent) originally budgeted for the resident adviser in the buy-in document of January 14, 1993, it may also show there is less need for technical assistance from Dakar and Washington as the project progresses, which is a sign of the success of the project.

### **6.4 Other Management Deliverables**

Apart from increased availability and consumption of contraceptives, in terms of other management deliverables, the project management, both from the central level at the DSFC (resident adviser) as well as from Dakar and Washington, appears to have accomplished some of the main deliverables as described in the buy-in document:

- Preparation and distribution of the Contraceptive Management Procedures Manual and supervision checklist (effective 1993)
- Analysis and dissemination of FP logistics data (ongoing)
- Preparation of CPTs (effective 1993, 1994)
- Assessment of FP transportation and storage needs (effective March 1994)
- Technical and administrative support in FP logistics training: follow-up to district training, and preparations for arrondissement training, including curriculum development (effective 1993, 1994)
- Coordination with other FP programs (e.g., AMPPF), donor agencies, and USAID/Mali (ongoing)

### **6.5 Management Areas Needing Further Attention**

There would appear to be, however, a few areas in the buy-in's project management that still need some attention.

#### *6.5.1 Funding and Budget Management*

Funds for the buy-in (US\$249,717) are almost all allocated for salaries, travel and transportation, communications, and other minor expenses. All funds for actual operations, e.g., training and field visits, have to come from another source, in this case from the USAID-funded bilateral Community

Health and Population Services Project. This funding for the training and field visits is approved by the Coordination Unit of the PSPHR, which is a multi-donor-funded project.

This means that whenever training or field supervision is planned by the buy-in, there has to be an application for the funding, which must be approved and released by the PSPHR (out of the CHPS funding) as well as approved by USAID/Mali (see Appendix G). This procedure can take time and may lead to delays. It may also represent an inhibiting factor for the project management. The PSPHR might also be taken by surprise when funding is requested and may wish to know details of the purposes, which, though reasonable, may lead to further delays. The project does not have its own allocated vehicle and any travel depends upon a vehicle being available either from the DSFC or PSPHR.

If there is sufficient forward planning in applying for funds, there should be minimal problems. For example, the budget for the training of arrondissement personnel scheduled for July–September 1994 (US\$47,000) was approved by USAID/Mali, through the PSPHR, in April 1994 (see Appendix G). However, it is the short-term funding procedure for the buy-in's operational activities which may be having an inhibitory effect upon the field supervisory and monitoring function of the project. Furthermore, the buy-in's local operating capacity is limited in that almost all its own budget is allocated to local and external management technical assistance.

**Recommendation. It is recommended that, every six months, in advance, an operational plan and budget be prepared by FPLM Resident Advisor for the funding necessary to carry out all work-related activities, such as training, information gathering, and field visits, and be submitted to USAID/Mali and the PSPHR through DSFC management. When approved, these funds, as well as transport, should be made easily available to the project with the minimum of delays, as and when required.**

**It is also recommended that at this midway stage, an operational plan and budget be prepared for the remainder of the expected life of the buy-in (April 1995) and be submitted to USAID/Mali and the PSPHR by end of July 1994. This should reflect the ongoing and additional activities planned for the rest of the buy-in (see above).**

In the end, it is important for all (USAID, GRM) to know how much the logistics improvement efforts have cost in total, not only the technical assistance component addressed through the buy-in to FPLM. This will enable a more accurate picture of its scope to be obtained, cost effectiveness assessed, and managerial control improved.

### *6.5.2 Supervision and Monitoring*

FP logistics supervision and monitoring is crucial and is a function which does not appear to be working very well at the present time all down the chain of management. The problems which are occurring in stock-levels and contraceptive information reporting in the periphery (see storage and distribution below) are largely related to management supervision.

There is an apparent lack of management expertise and motivation at the levels of the regional and district directorates which is leading to procedures not being followed, information not being

transmitted, deliveries not being made on time, and feedback from the DSFC (retroactive information) not being used. These weaknesses have been well identified by the Resident Advisor, even in areas as close at hand as the Bamako district (see Rapport National de Suivi de la Formation en Gestion de la Logistique des Contraceptifs, MSSPA/DSFC, Mme. A. Toure, Mme. A. Traore, November 1993, Conclusions: Appendix H).

One-time training in FP logistics management is not enough; there has to be a follow-up in the field to encourage, motivate, and advise the implementation of the system, at both regional and district levels (and later this year, at the arrondissement levels).

Under the original buy-in Delivery Order No. 05, it is stated under paragraph 4, Supervision System, that "The contractor will collaborate with MSSPA/PSPHR to ensure that logistics management is incorporated into the existing MSSPA supervision system." From all the observations of this consultant in the field and from discussions at the central level, it does not appear that this goal has yet been achieved or is in the process of being achieved.

Further, it is not likely that, with the expansion of the project resident adviser's responsibilities to cover the further development of the Logistics Information System, as well as coordination with other FP programs and donors, the monitoring of the SOMARC and CBD programs and other activities planned under the buy-in under 5.1 above, sufficient time will be available to the resident advisor for the supervisory and monitoring function, which will require considerable traveling in the field.

**Recommendation.** It is recommended, therefore, that provision be made to strengthen the central management supervision and monitoring function. This might be done either through defining more clearly the job responsibility of existing supervisory staff at the DSFC (a supervisor for MCH/FP is already in place but may not yet be carrying out a sufficient FP logistics supervisory function) or a reallocation of function of other staff to work more on FP logistics supervision. The operations of this supervisory and monitoring position should be closely coordinated with those of the FP logistics management, and should be able to receive sufficient resources in terms of travel funding and transport. It is recommended that each region be visited at least once a quarter and inputs should be made at regional, district, and arrondissement levels (see Appendix K).

The strengthened supervisory and monitoring function will help avoid stock-outs or low stock situations developing in the field, monitor and encourage the flow of information to and from the central level, and keep the level of expertise and motivation high overall. It will work with the FP logistics supervision checklist; it will regularly report on logistics management functions at all levels. It will also work toward the integration of FP logistics monitoring into the MSSPA monitoring system, fostering close coordination and communication of FP management with and between regional, district, and arrondissement health management.

### *6.5.3 Coordination*

One of the major deliverables under the buy-in and one of the key objectives of the resident adviser is the development of a satisfactory coordination function between all parties interested in FP in

Mali: the MSSPA, the CHPS/PSPHR Project, the other parts of the DSFC, USAID, private sector FP providers and programs, other FP donors, e.g., UNFPA.

With all the FP activities going on in Mali, in both the private and public sectors, and sometimes a mixture of the two, with different approaches, different supply sources, different policies, and different service strategies, coordination is becoming a major task.

It does not appear to this consultant that the resident advisor has had sufficient time in which to develop this coordination function fully so far. The visits of the RLA from Dakar give some impetus to this function, particularly related to the CPTs, and it is planned to hold quarterly meetings with other FP programs and donor agencies from the second half of 1994, which might improve the situation somewhat. However, it appears there is a wide gap in awareness at the DSFC about what other FP programs are doing, and there appear to be different programs going on in the same regions and districts which could cause confusion to FP providers and clients.

For example, a visit to Segou revealed that a Dutch government-supported essential drugs pilot program in two districts is distributing/selling three types of oral contraceptive (at CFA 100 and 120/cycle) of which two are of a dosage that do not correspond to the ones normally supplied to the national FP program through USAID, the International Planned Parenthood Federation (IPPF), or UNFPA.

In some regions, e.g., Mopti, contraceptives are being charged for in Ministry of Health facilities and FP clinics under the cost-recovery program whereas in others, e.g., Sikasso and Kayes, they are still being provided free of charge.

Cost-recovery Policy. The policy of the Government of Mali/MSSPA toward cost recovery of contraceptives in the public sector does not seem clear to some of the regions. It has been stated to this consultant by the director of the Ministry of Health, Dr. Coulibaly (interview Wednesday, June 15), that it is not the wish of the MSSPA/DNSP to charge for contraceptives in public health facilities at this stage, but that it should first be seen how the recently re-launched essential drugs cost-recovery program goes and that a study be made to assess the feasibility of charging for contraceptives before a decision be made on implementation.

AMPPF. The future activities of AMPPF also need to be more coordinated to assess their interrelationship and linkage with those of the DSFC. With the strengthening of the government FP logistics system, there is less and less validity for the AMPPF's antennes to hold stocks for government facilities. They were stocked originally to help out in cases of government facility shortages, but, as movement of stocks through AMPPF slows down (see Appendix J as illustration of slow stock movement), this function may gradually be phased out as the government logistics system improves.

Indeed, on the field visits carried out by this consultant, it was observed that there was little movement in stocks of orals, injectables, and IUDs held by AMPPF antennes. This did not always mean the government regional stocks were always optimal; sometimes there may have been a lack of communication between the two.

According to an agreement with the Ministry of Health, AMPPF does not provide contraceptives to clients directly, except for in its clinic in Bamako and for condoms in its regional antennes.

What then is to be the future role of AMPPF, which receives contraceptives from USAID and from IPPF? According to its national director, it plans to turn its attention to supplying the private sector more, but it is not clear which private sector, or at what price, and with what products. Will this new policy include USAID-supplied products? If so, what will the effect be upon consumption? How will AMPPF compete with SOMARC and CBD programs?

These are questions the FPLM should assist in coordinating the answers to and advising the DSFC directorate accordingly.

SOMARC and Other Programs. The SOMARC program working with the PPM, the Community Based Distribution Program, as well as the needs of the PNLS, will also require careful coordination. It is important that the MSSPA/DSFC and USAID are kept fully informed of these developments, not only for CPT preparations and monitoring, but also in terms of national policy.

UNFPA. From discussions with UNFPA (interview Mr. Traore, Wednesday, June 15) it was apparent that the requirements of the DSFC for UNFPA-supplied contraceptives for 1995 have not yet been passed to UNFPA by the DSFC, although preliminary discussions with UNFPA took place on the visit in April of the FPLM RLA from Dakar. This is an area where coordination and communication between UNFPA and the DSFC can be strengthened through The FPLM Project.

This function is critical. UNFPA cannot be expected to supply products at short notice; it has its own procurement procedures which can sometimes take more than six months, unless ready stocks are held. As UNFPA supplies some items which are not (yet) provided in sufficient quantities by other agencies, e.g., Eugynon and injectables, any delays in passing requirements to UNFPA could lead to out-of-stock positions for important items.

NGOs. The needs and activities of the Groupe Pivot, from which all other NGOs in Mali are expected to draw their contraceptives, have to be closely coordinated and monitored, as well as special projects such as NORPLANT.

Conclusions. From all experience so far, and from discussions with the various FP organizations and agencies, there would appear to be a considerable amount of FP logistics coordination necessary under the buy-in, which is at present not being totally achieved. This might lead to problems in over- and under-stocking.

**Recommendation. It is recommended that, in the remaining period of the buy-in, more attention be given to developing the management capacity to coordinate and monitor the activities and programs of the different organizations active in FP in Mali and that reports and recommendations be prepared on a regular basis for MSSPA/DSFC management as well as USAID/Mali. As a first step in this process, a meeting of all FP interested parties should be held at least once a quarter, with the FPLM local management in the chair. (This recommendation was actually made by the FPLM team in February 1994, and is already being acted upon—the first such meeting is scheduled for July 25.)**

#### *6.5.4 Future Directions for Project Management*

It is considered by this consultant that the planned management activities for the remainder of the buy-in (see Chapter 5) seem relevant and important to the program, and should, with addition of other management functions recommended, help enable the buy-in to further strengthen the national system of FP logistics management and thus help achieve its primary objective. Of particular importance appear to be the training of the arrondissement level, further development of the logistics management information system, supervision (particularly in the field), forward operational planning and budgeting, and coordination.

#### *6.5.5 Favorable Progress of Buy-in Project Management*

By most of the major indicators, including longer-term ones, it would appear that the buy-in project management, whether in Washington, Dakar, or Bamako, is satisfying most of the current managerial and technical assistance needs of the project and making a significant contribution to the development of a strong and sustainable FP logistics system. The prospects of achieving the major buy-in objectives and deliverables by the end of the buy-in period are reasonably good.

However, the more long-term objectives of the national family planning program and the implications for family planning logistics will need to be addressed in more depth. This process should be started within the life of the current buy-in and continue into a future possible technical assistance period. It should become institutionalized into the MSSPA/DSFC's planning process.

#### *6.5.6 Risk Factor*

However, the major weakness in the present management structure is that much—probably too much—of the expertise is concentrated in one person, the resident adviser, who is an FPLM/JSI employee.

Unless the project is to run indefinitely with external aid support, which seems neither desirable nor even necessary in view of the present level and development of national expertise, the risk exists that at the time the project is fully integrated into the MSSPA/DSFC's system, on national terms and conditions, the present resident adviser incumbent may seek other employment unless ways can be found to maintain her project terms of employment.

The departure of the resident adviser at this stage would place the project management in considerable jeopardy, and represents one of the major risk elements in the project so far.

#### *6.5.7 Need for Back-up Pool of Managerial Expertise*

It should therefore be one of the buy-in's major objectives over its remaining life to draw other DSFC personnel into the work of family planning logistics management so that there is a back-up pool of expertise, particularly in such areas as logistics information management, assessment of needs (CPTs), and coordination.

### *6.5.8 Creation of a FP Logistics Management Team at DSFC*

It has already been recommended above that FP logistics management should be transferred from a one-person function to that of a team. This FP logistics management team should have one coordinator responsible for the overall working of the team (policy and administration), as well as for certain technical functions, supported by at least two other members, each with distinct and clear responsibilities.

Thus a team of three might have the following division of functions: 1) coordination/CPTs/information management systems, 2) training, including curriculum development, materials, follow-ups, etc., and 3) distribution supervision and monitoring. Each member of the team would have insight and training relating to the work of other members of the team so that, in the absence of one member, there would always be a back-stopper.

However, this development of staff, cross-fertilization of functions, and integration into the MSSPA/DSFC system and structure will not be a short-term matter and may take one to two more years after the end of the present buy-in to accomplish. It is, however, suggested that a start to the process be made within the present life of the buy-in and become one of the major objectives of any project continuation or extension.

Once this FP logistics management team is fully operational, perhaps by the end of 1995 or early 1996, there may not be a need for significant external support. This could be limited to one to two visits a year for the purposes of the CPTs and coordination with other programs and donors and the same number of visits from a logistics information management specialist to further improve and expand the FP information system.

**Recommendation. Family planning logistics management in Mali can and should be carried out by a multi-disciplinary management unit within the structures of the MSSPA/DSFC. The present focus on one resident adviser should be broadened to include technical support to a strengthened DSFC FP logistic management team with clear and distinct functions, with the coordinator reporting directly to top management of the DSFC. This team should be fully integrated into the MSSPA/DSFC structure and systems (see Appendix K).**

**The setting up, operationalizing, and integration of this team should be one of the main objectives of the present and any future buy-ins. It is suggested that a target date for the start-up of team operations could be early 1996. Short-term external technical assistance will probably be necessary over this period and in the first year the team functions, particularly in such areas as contraceptive needs assessment (CPTs), logistics information systems, and coordination with other programs and donor agencies. However, with increasing local skills in FP management, some of this technical assistance may be found locally in Mali and may not need necessarily to come from Dakar or Washington.**

## **7. TRAINING**

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The training component of the FP buy-in would appear to have been one of the most successful. It had a good start, due to the long-time training expertise in FP of the buy-in resident adviser Mme. Traore, as well as previous work in assessing needs and developing suitable curricula and materials under other programs, such as IFAHS as well as the overall FPLM II program.

### **7.1 The FP Logistics Management Training Manual**

The FP Logistics Management Training Manual produced in 1993 is considered by this consultant to be a clear and practical training material. It appeared to be much appreciated by the health and stores personnel who had received the training, and on field visits was found to be used fairly frequently as a reference document. In almost every FP facility visited in four regions and the Bamako district, the Training Manual was easily produced upon request by the FP provider, usually the midwife in charge, and most were still familiar with its contents.

A few observations/suggestions: Regarding the level of stocks to be held at the different health units and stores, a minimum as well as a maximum stock level is given (page 9). Yet in the training (page 33), it is taught that "Pour tous les niveaux, la quantite a commander est egal au stock maximum moins le stock restant"; also in the stock usage/order forms (STS), managers are taught to always keep stocks up to the maximum levels.

The necessity in the system for FP personnel to calculate minimum stock levels, which are in any case too low (one month's usage at district stores and rural health units), may in some cases be confusing and encourage midwives and store managers to draw down to these levels. This tendency may be a reason why several out-of-stock situations were observed on this evaluation.

Perhaps the columns "maximum and minimum stock levels" might be substituted by one column headed "Optimal Stock Level" which would be equivalent to the present maximum stock levels and which would provide the basis for orders.

### **7.2 Quarterly Stock Situation Reports**

The form Situation Trimestrielle des Stocks (STS) or quarterly stock report (see Appendix L) is used also as an order form. Apart from the tendency observed above—that needs are sometimes being entered more in line with minimum stock levels, even when stocks are running low—there is also a danger that it may take considerable time for STS from the district level to travel to the regions and, if there are sufficient stocks there, to be delivered accordingly to the districts. By the time this happens, the districts may well have run out of stock. There are procedures for emergency orders in the training curriculum, but these do not seem to be used.

It would seem advisable in future training to emphasize that ordering does not have to wait until the end of the quarter, particularly when stocks are beginning to run low.

Section V11–Use of Logistics Data: It is not certain how useful or practical this section is for FP field managers. It is hardly likely that the hard-pressed midwives would have the time to complete the evaluation form (formulaire systeme-seuil), or to estimate the couple years of protection (CYP) or contraceptive prevalence rates (CPRs). This is useful data for the regional and central levels, however.

Annex: Available Contraceptives and their Dosages: There would appear to be an error in the dosage of the estrogen component of the combined low dose (Lo-Femenal and Microgynon). Perhaps this should read 0.03mg and not 0.05mg. Also, perhaps it would be useful to include the dosage of the progestogen component, i.e., 0.3mg norgestrel for Lo-Femenal and 0.15mg levonorgestrel for Microgynon.

Also, the dosages for the progestogen-only pills are not clear in the text: Microlut is normally levonorgestrel 0.03mg and Ovrette 0.075mg norgestrel.

Further, it may be useful to mention in this section that there is a difference in duration of action and hence dosage frequency between the two injectables Depo-Provera and Noristerat, Depo injections every three months, and Noristerat every two months. Many of the FP providers were not aware of this.

**Recommendation. It should be clearly established in the Manual and in training sessions that it is the maximum stock level that should be maintained and that use can be made of the emergency order procedure to maintain such levels. Emergency order procedures do not have to await the preparation of the STS at the end of the quarter.**

**The overall product knowledge of FP providers (midwives and nurses) met on the Mission field visits showed some gaps; it may be advisable to include some more time in this area in future training. Not only will this knowledge make the providers more efficient and motivated, it will also increase the confidence of the FP clients in the service.**

### **7.3 Logistics Supervision Questionnaire**

A FP logistics supervision questionnaire was developed in 1992 and made available to all management levels in the health system as part of the training procedures. Though quite comprehensive, this questionnaire or checklist is perhaps too detailed for regular use, and this consultant found little evidence to show that it was, in fact, being used at all.

There may be a need to reduce the questionnaire, or "supervision guide" as it is called, to a shorter, more practical version which takes not more than 10 to 15 minutes to complete.

The FPLM management may well be able to review and suggest revisions. Some of the checkpoints could perhaps be combined. Space and time should be allowed for feedback by the health/FP personnel.

## **7.4 Training Teams and Courses**

Training teams are in place and operational at the central (DSFC) and regional levels. The team at the central level is composed of the managers of the training and supplies department, closely advised by the resident adviser. The training manager is also a member of the Interinstitutional Training Group (GIF), as the DSFC is the technical service agency responsible for the "population" component of the PSPHR.

The regional training teams have been closely involved with the training of the districts as well as follow-up training and monitoring activities.

One of the first activities of the FPLM buy-in was to assist a DSFC mission to carry out a survey of FP logistics management training as carried out over previous years and determine the needs for follow-up training (recyclage) or changes in training curricula.

This mission visited four regions as well as the district of Bamako in the period March–October 1993 and established the strengths and weaknesses of the current levels of training in FP logistics management in the regions and districts. These findings (DSFC report, November 1993, summary page 27, Appendix H) showed that, although much progress had been made, there were still several FP management areas that were weak or poorly understood, and this became the basis for regional and district refresher training that was held in early 1994.

Furthermore, at a workshop held in August/September 1993 with assistance from the training adviser of JSI Washington, key central level representatives of the country's major family planning institutions were also trained in FP logistics management.

Training teams have been identified at the district level and will become operational with the start-up of the arrondissement (rural health) training program scheduled to begin July 1994. This will be the major training intervention of 1994 with almost 400 arrondissement FP logistics personnel to be trained. As there are presently 285 arrondissements in the country, this training should produce an average of 1.3 trained persons per arrondissement.

## **7.5 Conclusions**

The level of training in FP logistics management is one of the crucial elements in the success or failure of the national FP program and in the present buy-in. As in previous support programs, the DSFC and the project have given due emphasis and level of effort to this component.

From the DSFC's own findings (report November 1993) as well as this consultant's observations, there is still much work to be done until the key FP managers at regional, district, and arrondissement levels fully understand and operate the system efficiently. Logistics training affects all aspects of FP management—collection and reporting of vital data, ordering, storage, and distribution, and service to clients.

Unfortunately, because of security problems, it still has not been possible to train and follow up personnel in the northern regions.

There is evidence to show that suitable materials have been developed, trainers have been adequately trained and are operational, suitable curricula have been developed, and large numbers of FP field service providers—in the regions accessible to travel—have been trained and are operating the system generally satisfactorily.

However, due to continuing changes in personnel, new personnel entering the health service, and the needs for refresher training and new training of arrondissement workers, the present level of FP logistics management training should not diminish over the rest of the buy-in period. The planned training of arrondissement personnel should take place. Refresher training of district/regional staff should be considered for the first part of 1995.

**Recommendation. Training in FP logistics management should become an integral part of the MSSPA/DSFC training program and should cover all health/FP/stores personnel in the nation on a continuous basis. It needs to become fully institutionalized. This should be one of the main aims of this and any future buy-ins.**

**This consultant believes there should be suitable expertise in the MSSPA/DSFC and otherwise in Mali for these training needs to be covered without external assistance. However, external funding support for such training would appear to be a necessity, at least until the time when national resources are sufficient. Such support may well continue to be available from The CHPS Project. However, central training team/project management should ensure that programs, budgets, and funding requests are well-documented and presented in a timely manner to DSFC management for submission to USAID/Mali and the PSPHR.**

## **8. LOGISTICS MANAGEMENT INFORMATION SYSTEM AND PREPARATION OF CPTs**

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### **8.1 Logistics Management Information System**

A well-functioning LMIS is essential to the efficient and accurate preparation of the contraceptive procurement tables and hence the supplies of family planning commodities coming into the country. It is also an effective management tool to determine the performance of the logistics system, and in return, to assist FP managers in the periphery in the better performance of their tasks.

The LMIS developed in Mali includes the manual stock/consumption/ordering/receiving reporting system as used by the health/FP managers at the central, regional, district, and arrondissement levels; analysis and retroactive reporting at the DSFC central level; and aggregation of data from Ministry of Health and other (e.g., AMPPF and SOMARC) sources necessary for the preparation of the contraceptive procurement tables (CPTs).

### **8.2 Expected Outcomes and Activities of the Buy-in**

The expected outcomes and activities of the buy-in include the following:

- A reliable flow of logistics data to managers at the central, regional, and district level for the monitoring of supply status and the preparation of annual forecasts
- A system for the collection and aggregation of logistics data for analysis at the central level

Further, on page 6 of the Delivery Order No.05 document, after the LMIS is fully operational, the contractor will be expected to conduct training for relevant MSSPA and CHPS/PSPHR staff in forecasting contraceptive requirements for Mali's programs.

Earlier, on page 5 of the document, the automation of the LMIS is discussed:

After the manual LMIS is operational at all levels (end of 1993 earliest) and pending the availability of additional set-aside funds, an assessment of automation needs should be completed with technical assistance from the contractor. Following the assessment, it is expected that appropriate software will be customized and installed during 1994. Relevant training of key staff will also take place in 1994.

## 8.3 LMIS: Progress to Date

### 8.3.1 *Information Flows from the Field*

From evidence gathered on field visits, there appears to be a well-established flow of information at least from the district levels to the regional levels, and from the regions to the centre DSFC in Bamako. This information is manually prepared, and its main "vehicle" is the situation trimestrielle des stocks (STS), or quarterly stock report (see Appendix L).

With some exceptions, the STSs are conscientiously and accurately prepared at the level of the districts, as are the individual stock cards (fiche de stock) and the daily record of usage. The STSs are then sent to the next higher levels and serve as indicators of stock levels, consumption (issue to acceptors), and supply needs.

The system, as so established, appears clear, practical, and useful. However, it tends to happen, as described above, that districts do not cater sufficiently to the needs of the arrondissements, whose own personnel are not yet trained in forecasting needs and ordering in a timely manner. Regions may not stock enough for the needs of the districts, and often the delivery times between all levels are underestimated. Districts tend not to use the emergency order procedure. Indeed, it was mentioned several times that emergency orders were not popular with regional supplies management and tended to be ignored. For some products, a small starting base (e.g., for the injectables) leads to a continuation of low usage and low stock levels. In general, stocks tended to be kept low because of small or unsuitable (hot, dirty) storage facilities.

All these factors are contributing to a situation where, on field visits to four regions in June 1994, almost all the health/FP units and stores visited—even large clinics in the district of Bamako—were very low or out of stock of at least one major contraceptive item. This happened despite the stocks at the central stores in Bamako being quite sufficient, even over-stocked in some cases. The injectables were most affected by this situation. These situations appeared in spite of STSs being diligently filled in and dispatched to the next level in a timely fashion.

The maximum/minimum column appears to confuse some FP personnel; perhaps just one level should be given, an optimal level corresponding to the maximum. Furthermore, at this building-up stage of the national FP distribution system, more use should be made of the urgent order procedure. The present STSs do not include all products in the national distribution system, and some items listed are no longer supplied. They also include other MCH products, however, this part of the form is not filled in.

### 8.3.2 *New Health Information Format Under Test: Quarterly Activities Report*

A new, integrated health/FP data collection form is presently under field testing under a program coordinated by the PSPHR in an attempt to collect and analyze all important health/FP information in a relatively simple and practical format which would not pose too heavy an administrative burden upon health centre personnel. (See Appendix M.)

Although this new activities report allows for a reasonable amount of information regarding FP, it should not replace, in its present form at least, any of the logistics management and reporting forms already in place. However, some additions or revisions to the new quarterly activity report under test might enable one or two of the present FP activity reports (e.g., the monthly report prepared by each FP unit) to be suppressed, which would lighten the workload on midwives in particular.

The FP logistics management team should follow the testing and further development of this quarterly activities report and make recommendations and suggestions where necessary.

**Conclusions. The present manual system of information reporting from health/FP units is well-established and procedures appear to be practical and acceptable to users. As designed, it is providing project management at the central level with valuable information.**

However, it is a somewhat cumbersome method in its use as a trigger for supplies. Some improvements in the lay-out may be desirable; the maximum/minimum columns may lead to under-ordering and eventually stock-outs. It is not yet seen at all levels outside the centre as an essential management information tool, and some regions are consistently late in sending them into Bamako, as well as under-using the information to improve logistics in their own areas of responsibility.

**Recommendations. The present manual FP LMIS should be still further developed and refined so that it corresponds to needs. However, it should not become too burdensome for hard-pressed FP workers, e.g., midwives.**

Certain FP information should be collected and analyzed as an integral part of the MSSPA/DSFC health reporting system, however this is not likely to replace but rather support the present system of logistics information, which is crucial for stocks and supplies. Health/FP personnel at the arrondissement level still need to be trained in use of the FP LMIS, and some refresher training and supervision at the regional and district levels appears to be necessary.

Until the present manual system is more generally in use and evaluated and information flows more targeted to needs, it would not appear urgent to proceed with automation of the system, at least not in 1994. This, however, may be considered for 1995, as has already been proposed by FPLM management and USAID/Mali. It is recommended that an in-depth evaluation of the present system be first carried out, and the cost/benefits of automation studied.

The FP logistics management team should play a role in the further development of the proposed new quarterly activities report so that it can be adapted to suit FP logistics needs as much as possible before introduction.

### 8.3.3 Information Analysis: Flows to the Field

The system of information analysis and retro-information to the field has so far only produced one published and distributed document—for the first quarter 1993—and this was published in late January 1994, almost one year later. Even at this stage, the DSFC had still not received data from the northern regions, and others had been very late in sending in their reports.

A second document—for the last semester 1993—was prepared by the DSFC with assistance from the logistics management team but has not yet passed through all channels at the level of the DNSP/MSSPA for general distribution to the regions.

Although the first quarter 1993 100-page document has some interesting charts and tables, highlighting over- and understocked positions at regional and district levels as well as a sort of school report card on efficiency in filling in and sending the different forms, it is not clear how useful this document will be as a management information tool to the periphery, particularly in view of its late production and distribution ( see Appendix N).

Retro-information to field managers is to be encouraged; it increases managerial performance and motivation. However, it might be possible to present such information in a more useful and timely manner. However, this will depend on data being received from districts and regions promptly, which at present, due to lack of supervision and motivation in some areas, cannot be guaranteed.

Furthermore, it does not appear that the type of information at present being fed back to the field is of great significance or utility to regional and district FP managers. Other types of information, such as data relating to growth of contraceptive prevalence by region and nationally, method mix, details of other FP programs, (e.g., SOMARC and CBD), central stock levels and supply programs, may be found more useful and could be developed.

**Recommendation. Unless the present form of retro-information can be issued in a time frame which makes it relevant to FP field managers, it may be useful to consider other methods of information collection (such as the proposed new quarterly activities report), analysis, and dissemination. It may also be desirable to assess the cost-effectiveness of the November 1993 and later retro-information documents presently under preparation, the type of information contained in them, and the extent of their use.**

**In this assessment, it would seem appropriate to involve regional and district level health management. New types of information and methods of analysis might be developed in this assessment. FPLM should play a key coordinating role in this activity.**

## 8.4 Contraceptive Procurement Tables

CPTs are at the core of FP supplies management and one of the principle activities of the buy-in. Specifically, the contractor is expected to assist in the completion of annual CPTs working with each of the Mali FP and AIDS control programs. The contractor is also expected to conduct training

in 1994–1995 for relevant MSSPA and CHPS/PSPHR staff in forecasting contraceptive requirements.

Both the COCOPLAN (see Appendix O) and NEWCPT (see Appendix P) computer programs appear to offer practical and user-friendly methods of calculating FP commodity needs. Assumptions need to be made regarding method mix and rate of acceptance. Also, it is important to know what commodities (type and quantity) other FP suppliers and programs—in the private as well as the public sector—are likely to bring in and when.

Both programs rely for their accuracy on the quality of information and assumptions. COCOPLAN calculates quantities and types of contraceptive needed for the future according to present data on population, WRA, CPR, and method mix. The program can also "back in" to the program by adjusting the above figures and rates so that they match what has actually been consumed in a given year and then make projections.

NEWCPT is more related to procurement and supply programs. It takes known beginning stocks, accepts assumptions for likely consumption patterns, adjusts for en route orders, then calculates stocks to be ordered based upon desired end of year stock levels, taking into account the needs of the different programs and likely changes in product mix.

Both programs are in use for the Mali FPLM buy-in and provide project management with key consumption, procurement, and supply data to the DSFC, USAID/Mali, USAID/Washington, FPLM II, and the buy-in. Needs of other organizations and agencies active in FP in Mali who draw some of their supplies from the USAID program, such as AMPPF, Program Against AIDS, SOMARC, and CBD, are also included, even for products which are not supplied from USAID, such as Eugynon.

Both programs can be said to be reasonably accurate tools for supplies management, however, both depend to some extent on assumptions, and sometimes fashions change. There is presently an overstock of one type of foaming tablet which has caused orders to be canceled. Use of injectables continues to increase, but supply sources are not yet fully capable of providing sufficient quantities.

It is one of the objectives of the buy-in that expertise and managerial capacity in preparing the contraceptive procurement tables for the use of USAID and other suppliers be fully developed at the MSSPA/DSFC. By this stage, the only work necessary for USAID/Mali or others, such as UNFPA, should be to pass on requirements derived from the CPTs to their national procurement agencies and arrange shipments.

There has been considerable technical assistance provided to the buy-in on this important function: the resident adviser has been trained in Washington by the contractor, JSI, and at least three visits have been made to Mali by the regional logistics adviser to the buy-in and a fourth is scheduled for later this year.

However, it is this consultant's opinion that the expertise for preparing CPTs has not yet been effectively transferred to the DSFC or MSSPA, which is one of the major deliverables of the buy-in. The planned training course in this function has not yet taken place. Expertise in CPTs resides largely in one person, and this is a risk factor. If that one person leaves or is reassigned before others in the DSFC have been trained, the logistics program could be seriously affected.

However, it is considered that sufficient expertise in CPTs has been transferred by JSI Washington and the FPLM RLA to the resident adviser to the extent that future external assistance should be provided only perhaps once a year when the provisional CPTs are being finally reviewed prior to procurement.

There should be no need for more involvement of USAID/Mali staff in the preparation and operation of CPTs more than at present, which is confined mainly to order processing and follow-ups by a national assistant project officer through advice and coordination with FPLM project management. However, it would be advisable for staff responsible for FP projects at USAID/Mali, including supplies, to have a working knowledge of contraceptives and forecasting techniques, including computer models, basic product knowledge, FP methods, types of product, and usage trends. This would help USAID/Mali maintain a critical and realistic watch over the CPT process and be able to question assumptions and figures. A deeper involvement, however, is not considered necessary or desirable.

**Recommendation. It is recommended that, at the next review of 1994/1995 CPTs scheduled for October 1994, the task of preparing future CPTs should be a joint responsibility of the DSFC FP logistics management team with external review assistance, at most once a year, just before procurement is begun.**

**Expertise at preparing CPTs should, therefore, be spread to others in the FP Logistics Management Unit as soon as possible, so that this activity becomes teamwork in the future and there is always a backstop in case one of the FPLM team is not available. This transfer of expertise should begin now and be consolidated on the next visit of the regional logistics adviser in October 1994.**

**It is further recommended that there should be no deeper involvement by USAID/Mali in the preparation of the CPTs than at present, which is largely a review and processing function, including shipment tracking. However, the FP project officers could benefit from training in FP forecasting programs so as to be better able to carry out critical reviews the validity and reliability of CPTs, a function which still has to be developed at the DSFC and which is crucial to FP supplies.**

**More use should be made of the CPTs in advising other FP supply organizations such as UNFPA and IPPF, which are not yet using such forecasting models as NEWCPT and COCOPLAN.**

**It is further recommended that the importance of the CPTs to the national FP supply program of Mali as well as to USAID's programs and budgets justify them serving as an opportunity and focal point for future external technical assistance.**

## 8.5 Coordination with Other Family Planning Agencies and Organizations

Preparation of CPTs on a national basis will require close cooperation and coordination with other FP agencies and organizations, not only those drawing supplies from USAID but also those receiving supplies from other sources.

Supplies received by AMPPF from IPPF and possibly other sources must be known and taken into account. The FP Logistics Management Unit should not only receive information from AMPPF but also advise this organization on what is available from USAID so that there is no duplication, and so that funds thus made available could be used for other purposes.

Close contact needs to be kept with private sector-type programs such as SOMARC and CBD and their distribution/consumption rates carefully monitored.

UNFPA needs to be advised on what products may be needed from that organization, again to avoid duplication, but also to provide the means for supplying FP items which USAID cannot supply, e.g., injectables and Eugynon. This point has been well made by the buy-in regional logistics adviser in his travel report of April 1994.

However, this consultant would not go so far as to advise against these organizations supplying one or two alternative products such as Microgynon (similar to Lo-Femenal) and Noristerat (similar to Depo-Provera) if there continues to be a demand, and if these organizations are still willing to do so.

Observations on this Mission's field visits showed that although Lo-Femenal is the most popular and most frequently-used oral contraceptive in government FP clinics, there are still some acceptors who find Microgynon more suitable. The situation is similar with Depo-Provera and Noristerat. Having more than one form of similar contraceptive types may also increase the confidence of women in the national FP service, as well as give FP providers more interest in their range of services.

Whatever is decided on national policy in this respect, however, the important factor is to include all FP products available in the national system in the CPTs and to clearly inform other organizations, such as AMPPF and UNFPA, what the country's estimated needs are, what is being supplied from USAID, and what will be expected from other sources and when. This aspect is particularly important in the case of injectables from UNFPA, which, despite the relatively low stocks now in the central stores (approximately seven months) still have not (as of June 15) received a request from the DSFC (interview, Mr. Traore, UNFPA project officer, June 15, 1994).

**Recommendation. It is recommended that, in the preparation of the CPTs in particular and for the purposes of FP management in general, close cooperation and coordination be maintained by the DSFC FP logistics management team with other FP distribution and supply organizations so that all needs can be covered, duplication avoided, and goods arrive at the right time.**

**It is further recommended that the FPLM team monitor closely other, smaller pilot projects ongoing in the country (e.g., the Dutch-financed essential drugs cost-recovery program in**

**Segou region) which might be introducing into the system other contraceptives not already in the national program and which may, particularly upon expansion, lead to a plethora of different contraceptives in the system, confusion with FP service providers, and difficulties in preparing the CPTs. In this respect, it is recommended that either the Dutch project be asked to remove at least the oral contraceptives they are presently supplying in their essential drug kits or, if they wish to distribute contraceptives, they should use the DSFC's regular USAID supplies. These should, however, not be sold.**

**Furthermore, applications by any other agencies wishing to introduce other contraceptives into the national, public sector system should be carefully assessed by the FP Logistics Management Unit and management of DSFC before approval to ensure that they support the national FP program objectives.**

## **9. STORAGE AND DISTRIBUTION, INCLUDING TRANSPORTATION**

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An assessment of the contraceptive transport and storage network in Mali was carried out under the scope of the buy-in by a DSFC/FPLM team in January/February 1994. This evaluation and its findings are considered by this consultant to be of considerable importance to the improvement and development of the storage and distribution functions of the FP program. A copy of the assessments Executive Summary is attached as Appendix Q.

For the purposes of the current buy-in evaluation, an assessment of storage and distribution systems was also included in field visits carried out by this consultant in the period June 1 – 14 when four regions were visited—Segou, Mopti, Sikasso and Kayes—as well as the district of Bamako.

To a large extent, this consultant's findings correspond with those of the January team, the following point in particular: "The present contraceptive logistics system is not yet a constraining factor to the expansion of the family planning program." (Point 7 of the January team's Executive Summary)

Comment: As a **system**, this statement is valid; however this Consultant would **not** agree with the next sentence of point 7 which states, "The stock levels of contraceptives were generally well-maintained despite the absence of regular and reliable transport." This Consultant's observations were that stock levels were in many cases **not** well maintained for that reason, because there was a lack, in some cases, of regular and reliable transport. Indeed, it is hard to believe that stock levels could be otherwise without good transportation.

This consultant's findings were that in the majority of stores and clinics visited in the four regions and one district, at regional and district levels, there were often products out-of-stock or precariously low.

The reasons for this were mainly:

1. Transport Management and Supervision: Lack of a) good transport management and supervision (not lack of transport as such) and b) deliveries and transportation linked directly to receipt of quarterly stock reports which may be irregular, late, or inaccurate (corresponds to point 12 of the January team's Executive Summary).
2. Storage Facilities: The January team found that "there was no need to construct storage facilities at the Regional level, as construction projects financed by the PSPHR are already in progress, but that specific improvements be made to existing warehouses to make better use of existing storage capacity." (points 8,9, and 10 of the January team's Executive Summary)

This consultant found storage conditions at the regional level generally appalling and totally unsuitable for the storage of any medical supplies. Doors and ceilings were often falling apart, dirt and dust was everywhere, temperatures were in the high 30s (90s Fahrenheit), and there was generally no ventilation. The conditions at the district level

were not all that better. In the clinics, small stocks were kept mainly in filing cabinets—not the best storage, but adequate for day-to-day use.

This consultant believes that rapid action is necessary to improve the present conditions of storage at regional and district levels, at least to cope with current needs. Much could be done by small repairs, the provision of fans, opening of windows and other vents, and the supply of new shelving, at least until the new regional facilities are constructed. One of the most important and urgent tasks is to bring the temperatures in most storehouses down. If air conditioners are not available, good fans and ventilation will help.

A major program of improvement to stores at district and arrondissement levels would also appear necessary from observations made. Improvements would provide more space to cope with expansion of the system, including the needs of CBD and so forth.

3. Communication Links: Closer links are needed between the flow of contraceptives from the central to the field level and the flow of information from the field to the central level. (Point 13 of the January team's Executive Summary)

This consultant agrees completely with the team's findings. This closer link should be achieved by better training and better management and supervision at regional and district levels. There are wide gaps in the performance of regional and district management teams, certainly regarding FP and contraceptive logistics management. This needs to be improved. Other improvements include more visits to district and arrondissement units by regional teams, quicker responses to STSs, and more awareness of the need to have FP items in sufficient stock at all times.

4. Transportation: The January team believes that some of the stock and distribution problems identified can be solved by the availability of a truck, placed under the supervision of the DSFC/Bamako, for the delivery through the country of contraceptive supplies to regional warehouses.

Further, the January team recommends the purchase of a light vehicle for each region.

This consultant would agree with neither recommendation.

Reasons:

The current problems with transportation are not lack of vehicles, but poor transport management and planning. From Bamako central stores to the regions, if DSFC or other Ministry trucks are not available, a relatively economic and regular way would be to make an agreement with an organization such as the Pharmacie Populaire du Mali, which has a fleet of trucks regularly visiting all the regions, with perhaps the exception of the northern three (for security reasons) and Kayes (supplied regularly by rail).

A recent analysis (June 7, 1994) by the FPLM resident adviser Mme. Traore clearly shows that this alternative would offer the most cost-efficient and safe—in terms of experience in transporting medical supplies—method (see Appendix R).

This consultant has had several discussions with the PPM, which is also transporting and distributing for the SOMARC program. This consultant believes that the PPM may have the capacity and the means to improve significantly the present level of transport of DSFC FP items to the regions.

Roads to the regions currently covered are mainly good, and Kayes is relatively easily reached by rail. Naturally, individual trucks dedicated to FP supplies would be convenient, however, it would not be economic and would probably soon be used for other purposes. Problems of servicing and maintenance would also arise.

Supplying individual trucks would, in this consultant's opinion, separate the FP logistics program from the mainstream MSSPA/DSFC supplies management system even more, whereas the intention should surely be to integrate them more. This does not mean necessarily tying in the FP supplies system with that of the essential drugs program (DCI/generics) now being re-launched by the PPM. That program needs to be firmly established and running before a link-up should be considered. However, the essential drugs program, if successful, will provide the PPM with a firmer basis for its nation-wide distribution system and may become a logical, reliable, and cost-effective method by which to transport FP supplies.

The proposal of the January team to make available light vehicles for each region is also, this consultant believes, inappropriate and unnecessary. Observations showed that there is no lack of vehicles at the regional level. Moreover, the World Bank will shortly provide each region with another four-wheel drive vehicle. The problem is more with management of the vehicles and provision of funds for fuel and per diems so that the teams can regularly supervise and supply the districts.

The FPLM Project should endeavor to ensure that sufficient funding and access to vehicles are available to regional and district management for supply and supervision activities.

### **Recommendations.**

**1. Storage: Improvements need to be made urgently to regional and district storage facilities to provide adequate storage conditions for FP items. Where necessary, new storage facilities should be constructed or existing ones renovated and expanded. If other storage facilities are available, e.g., for vaccines or other sensitive medical supplies, these could be used for FP products in the meantime. Storehouse temperatures must be brought down. This can be accomplished to a large degree by the running of fans and opening of ventilation.**

**2. Distribution and Transportation: The present distribution system is hampered by irregularity and delays in dispatching quarterly stock reports and by problems (unavailability) of transport from the central level to the regions and from the regions to the districts. Improvements should be made by 1) improving training and supervision in the use of the STSs and 2) by using existing transportation methods, e.g., PPM from the centre to the regions and better access and management of regional vehicles for FP supervision and supply activities. FPLM management should play a key coordination role in strengthening the**

**storage and distribution of contraceptives over the life of this and possible future buy-ins, however, it is recommended that this function should be integrated into existing national systems.**

**Note: For delivering to the northern regions, e.g., Timbouctou, Gao, and Kidal, a good possibility may exist through the air transport company Missionary Aviation Fellowship (MAF) tied in with Sahel Air Services, Bamako.**

## **10. INSTITUTIONALIZATION AND INTEGRATION OF FAMILY PLANNING LOGISTICS MANAGEMENT, INCLUDING SUSTAINABILITY**

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### **10.1 Institutionalization**

There has already been a significant degree of institutionalization of the FP logistics management system under the buy-in. The resident adviser has her offices physically at the DSFC, she works closely with other involved personnel e.g., training, statistics and information systems, and supplies. FP logistics are firmly a part of the DSFC's health management system, giving sound support to the national FP program. At the regional and district level, the FP logistics system is well established in the health management system; this institutionalization will shortly be strengthened at the arrondissement level after the training program is completed by the end of 1994.

The buy-in's activities have undoubtedly strengthened the managerial and technical capacity of the DSFC to run the national FP logistics program efficiently. However, as described above in Project Management, to be completely effective there needs to be a more intensified transfer of skills to other DSFC management personnel, particularly in the areas of CPTs, management information systems development, and coordination with other FP programs and initiatives. Transfer of skills in these areas should be one of the main activities for The FPLM Project over the rest of the current buy-in and during any new buy-ins.

Furthermore, there needs to be more institutionalization of supervision and monitoring of the FP logistics system within the overall health management program at all levels—central, regional, and district. Especially at regional and district levels, this function needs to be seen as an essential part of health management activities. It should not be seen as a separate program with its own procedures, documents, forms, systems, training, and supply channels, but an integral part of the national health service.

For example, training in FP logistics should, in time, become a part of FP service delivery training, for all health/FP personnel; supplies and distribution of FP commodities should be included in the regular MSSPA/DSFC supply system, and FP management information flows should be included in the MSSPA MIS.

The FP management information system is still operating much as a vertical system within the DSFC; but this is necessary for the time being at least, for there is no equivalent supply system in the DSFC (e.g., essential drugs program) with which the FP logistics system could integrate. However, the system is well institutionalized at regional and district level, though health managers need more motivation and perhaps instruction in how to obtain and analyze FP data.

A new, comprehensive health information report (quarterly report of activities) is now being tested under coordination of the PSPHR; if successful, this new report will provide considerable FP data; in its present form, however, it will not replace the FP logistics information system, which should continue.

As the FPLM system is now set up, there seem to be few obstacles to the DSFC being able, in time, to manage the national FP supply and service program. This will reduce further the role of the AMPPF as a provider of FP commodities to the public sector. AMPPF is presently seeking to redefine its place in FP, which may well be more in educational and sensitization programs. With its present organization, it can clearly not compete with the DSFC's program.

## **10.2 Essential Drugs Program**

The evaluation Scope of Work (see Appendix A) raises points relating to the possible similarity and compatibility of the FP logistics program with that of the national Essential Drugs Program. An essential drugs program (EDP) is designed to make drugs of most need available to the population at lowest cost, but at the same time, maintaining acceptable quality standards. There is no doubt that essential drugs programs are the only effective way for any developing country (and some developed ones) to provide for the basic medication needs of their population.

EDPs are based upon limited lists of drugs selected for their efficacy, safety, cost, and practicality of use by health workers down to the lowest level. WHO's recommended list of some 250 drugs (which has remained largely the same since the first essential drugs list came out in the late 1970s) has been adopted, with minor adaptations, by some 70 countries.

Essential drugs are mostly generics, that is, out-of-patent multi-sourced products, and therein lies one of the weaknesses of EDPs, i.e., how to buy cheaply yet be sure of quality. There are many pharmaceutical operators who will offer very low-priced products but which may be low standard or even toxic. Often, a developing country, with no national testing facilities, and which is trying to obtain the most drugs for its money, will be at risk from such operators. Africa is full of such examples.

EDPs, therefore, to be successful, need very close attention to quality either through buying from reputable supply sources or having national testing facilities, preferably both. Local producers may be able to supply some items, but they suffer from having to import all raw materials, and usually their scale of production is too small for them to be competitive with large overseas manufacturers. Their quality also has to be checked rigorously.

In essential drugs programs there need to be strict specifications regarding type, dosage form, presentation, packaging and labeling, quality, and stability as a key part of procurement procedures. WHO's certification scheme should be used as a back-up; it is a government-to-government program which helps importing countries be sure of their suppliers' quality.

To be successful and sustainable, however, EDPs require the drugs to be sold at modest, social prices and the funds to be recycled back into the system to purchase new supplies. This has been one of the problems of many essential drugs programs; funds have not been fully recycled and programs have required increasing capitalization which many Ministries of Health have not been able to afford. Furthermore, as most drugs still have to be imported, local funds generated must somehow be converted into foreign exchange to buy new supplies, and this is not always possible for many countries.

EDPs, therefore, depend on several factors for their viability: their purchase/selling prices, their ability to generate funds and foreign exchange, their quality, and last but not least, their rational usage. When they are for sale in health centers, drugs have a habit of being over-prescribed and over-used. Reducing this requires good training and firm supervision.

In contraceptive supplies, many of the EDP risk factors are not present. Mostly the suppliers are well-known and reputable, with sophisticated technology and high quality standards built up over years. There are relatively few suppliers in the field, as the technology is still closely held. The few suppliers in existence produce on a massive scale and this enables them to offer large purchasers such as USAID and UNFPA very low prices, unmatched by smaller producers.

Contraceptive supply programs are, therefore, thanks to the work of USAID, UNFPA, and similar organizations (such as IPPF), already operating on the principles of essential drugs—efficacy, safety, low cost, and practicality of use. They hardly need to be linked with essential drugs programs. This may bring more complications than advantages—except for the area of storage and distribution/transportation, where certain economies could be achieved by distributing contraceptives along with essential drugs (see above under Supplies and Distribution).

There is unlikely to be a conflict between the essential drugs program, now being relaunched by the PPM with charges for drugs, and the national FP service which remains mostly free, except for the initial patient card. FP needs to be promoted and available to as many of the population as possible at the present time in Mali; drugs need to be available, but their over-use is not to be encouraged. Charges are, therefore, a reasonable way of keeping usage down to the most necessary.

People expect FP to be free, but are being rapidly conditioned to paying for drugs. There are few drugs in government hospitals and clinics; most patients have to go to the nearest pharmacy and buy them at retail prices, which have shot up since the devaluation and are still far higher than those bought for the public sector. The newly relaunched essential drugs program distributed by the PPM with social prices should make drugs much more widely available and affordable, and its objectives should be supported.

However, its viability depends on the critical factors mentioned above, and it will require skillful management as well as firm political commitment to make it a success.

**Recommendation. Apart from linkages in storage/distribution functions, which should now be studied by the FPLM, and reviews of the progress and level of success of cost recovery, it is not yet believed appropriate to integrate the FP logistics system into that of the essential drugs program. The disadvantages may outweigh the advantages.**

**Furthermore, it is not believed that there will be an inherent conflict in providing FP items free in government clinics alongside drugs that are sold. In time, it may be justified and desirable to make similar charges for FP items. However, for the time being, it would seem more desirable to have FP items easily available to all including the poorest, if the national FP objectives are to be reached.**



## 11. FUTURE DIRECTIONS

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The present situation of family planning in Mali shows that, although some (mostly USAID-supplied) contraceptives are now available most of the time in government health centers, hospitals, and clinics, the logistics management system has not yet reached a level of operational efficiency whereby the current needs for FP of the population are being fully satisfied.

The logistics system as being implemented is, however, likely to play a major role in this level being reached over time. However, it is not yet at the stage where it can be guaranteed to operate without considerable technical and financial assistance. Increasingly, some technical assistance may be available in-country or from the region, and perhaps future possible funding may reflect this, however, it is suggested that a certain level of external technical assistance in specialized areas will continue to be desirable and necessary for the foreseeable future.

The future needs of the Mali FP program may, therefore, best be served by a continuation and intensification of FPLM activities, with increased emphasis on transfer of skills in such areas as contraceptive procurement tables; development of the management information system into an effective managerial tool and its integration into the health information system; continuation of logistics training so that it becomes an integral part of MCH/FP training and continuing education in the MSSPA system; increased supervision at all levels (central, regional, and district); and following up plans for improvements in storage, transportation, and distribution.

An increasingly important part of FP logistics management in the future will be coordination of family planning activities of other agencies and organizations active in the field; monitoring of social marketing and community-based programs; studies of cost-recovery systems and recommendations for sustainability programs; and advice to and liaison with external aid and donor agencies so as to achieve maximum synergy and efficiency.

It is this consultant's overall conclusion that the FPLM buy-in, in the relatively short time it has been operational, has already made considerable progress in the strengthening of the national FP program in Mali and has achieved, and is in the process of achieving, most of the objectives (deliverables) of the project.

However, it is unlikely that some of these objectives will be achieved by the end of the present buy-in period or that the FP logistics management system will have reached a strong enough level of expertise and institutionalization for it to continue to operate effectively without technical and financial assistance for some time in the future. It is still a fragile system, working in a difficult and evolving environment. With continued help, there are good prospects it will develop into a sound and permanent base for successful FP service delivery in Mali.

**Recommendation. It is recommended that the present FPLM buy-in continues after the end of the current period (extended to end April 1995), with certain changes in emphasis, managerial structures and functions, operations, and objectives as described above.**



## APPENDIX S

### LIST OF CONTACTS

#### Bamako

PSPHR: Dr. Fatoumata Nafo Traoré, Director

Mr. Abdramane Maiga, Acting Director, Project Coordination Unit

Mr. Sega Abdoulaye Traoré, Social Sector Project Officer, Social Sector Project

DNSP: Dr. Mountaga Coulibaly, Director, National Public Health Directorate

Dr. Kané, Adjoint, National Directorate for Public Health

DSFC: Mme. Aminata Touré, Training Manager

Mme. Mariam Diallo, Supplies Manager

Mr. Djibril Semega, Chief ad interim, DSFC

Dr. Sangaré Medina, Head, Section MCH/FP

Mr. Mamourou Sangaré, Head, statistics, research and evaluation

Dr. F. Tandia, evaluation (Norplant project)

Mme. Aoua Diarra Traoré, Resident Adviser, FPLM/Mali

Magasin Central: Mr. Cheick Oumar Djakité, Head of Stores, DSFC

CHPS: Dr. Ismail Thioye, Director

SOMARC/Pharmacie Populaire du Mali: Mr. Mamadou Traoré

Population Council: Dr. Seydou Doumbia

AMPPF: Mr. Lasseni Sidibé, Executive Director

Mr. Yaya Djakité, Program Director

Mr. Adama Tounkara, Stores manager

UNFPA/FNUAP: Mr. Boubacar Traoré, Program Officer

Region Segou: Dr. Soma Coulibaly, Head of Health Division

Dr. Jdrissa Alidou Maiga, Planner

Mme. B. Sangaré, Regional Midwife

Region Mopti: Dr. Fodé Coulibaly, Regional Director of Health

Dr. Bojaba Diarra, Chief of Health Division

Mme. Kadiatou Traoré, Regional Midwife

Region Sikasso: Dr. Dicko, Chief of Health Division  
Dr. Oumar, Director of Health ad interim  
Dr. Sidité, Director, Central Health Centre

Region Kayes: Dr. Djibril Diakite, Regional Director for Health

USAID, Bamako: Ms. Lynn Gorton, Health and Population Officer, Office of Health and Population  
Ms. Carol Hart, Program Manager, CHPS/Washington  
Ms. Lucy Mize, Program Officer, Population/FP  
Mr. Madiou Yattara, Administrative Assistant, FP

USAID, Washington: Dr. John Crowley, Office of Population, Bureau for Research and  
Development

## APPENDIX T

MALI

Evaluation of Family Planning Logistics Management project

FPLM

May 23 - June 26 1994

Debriefing

1. At the end of the mission, in the last week before departure, three debriefing sessions were held, one with Dr. Nafo Traore Director of the PSPHR (Projet Santé, Population et Hydraulique Rurale), at which Ms. Lucy Mize of the USAID Nission, Bamako was present, and one with Dr. M. Coulibaly, Director of National Public Health (DNSP), at which Mme. Aowa Traoré FPLM Resident Adviser and Dr. Medina Sangaré, Chief of MCH/FP at the DSFC (Division of Family and Community Health) were present.

2. At both briefings, the main conclusions and recommendations of the evaluation were presented (See attached). Comments included:

- the necessity of involving regional and district health teams more in training, with appropriate allocation of funds, and of drawing on their expertise and preferences in the strengthening of the logistics management information system

- the necessity of improving storage and transportation at the regional and district levels

- the importance of training the Arrondissement personnel in the FP logistics system (as planned) and decentralizing the responsibility for FP logistics

- the importance of FP supervision, which may have somewhat vertical from the level of the DSFC/FPLM until the logistics system is better established, at which stage it should be integrated into the MCH/FP supervision activities.

- the desire for the DNSP/DSFC to continue to provide contraceptives free of charge, albeit with a small charge for an attendance card, until it can be seen that contraceptives could be afforded by all, including the poorest

- the advantages of continuing to operate the FP logistics system separately from the re-emerging essential drugs program, apart from possible synergies in transportation and distribution, at least until the viability of the essential drugs system is proven.

- the usefulness of having a truck provided for the DNSP which could assist in the transportation of contraceptives from the Centre in Bamako to the regions; and the non-necessity of providing more light vehicles to the regions.

The Executive Summary and Summary of Main Recommendations in the french version were presented to the participants.

The french language version of the full report should be available in about a month.

Gerald D. Moore, Consultant to USAID, Mali, the Poptech Project, Washington, DC

Bamako, June 24 1994