

A.I.D. EVALUATION SUMMARY - PART I

1. BEFORE FILLING OUT THIS FORM, READ THE ATTACHED INSTRUCTIONS.
 2. USE LETTER QUALITY TYPE, NOT "DOT MATRIX" TYPE.

IDENTIFICATION DATA

A. Reporting A.I.D. Unit: Mission or AID/W Office <u>USAID/Ghana</u> (ES# _____)	B. Was Evaluation Scheduled in Current FY Annual Evaluation Plan? Yes <input type="checkbox"/> Slipped <input checked="" type="checkbox"/> Ad Hoc <input type="checkbox"/> Evaluation Plan Submission Date: FY <u>87</u> Q <u>1st</u>	C. Evaluation Timing Interim <input checked="" type="checkbox"/> Final <input type="checkbox"/> Ex Post <input type="checkbox"/> Other <input type="checkbox"/>
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D. Activity or Activities Evaluated (List the following information for project(s) or program(s) evaluated; if not applicable, list title and date of the evaluation report.)

Project No.	Project /Program Title	First PROAG or Equivalent (FY)	Most Recent PACD (Mo/Yr)	Planned LOP Cost (000)	Amount Obligated to Date (000)
641-0109	Contraceptive Supplies Project	1985	09/89	\$7000	\$7000

ACTIONS

E. Action Decisions Approved By Mission or AID/W Office Director Action(s) Required	Name of Officer Responsible for Action	Date Action to be Completed
1. Prepare PIL's to extend PACD and to reallocate budget as necessary for completion of Project Activities.	USAID/Kirkland	09/30/88
2. Meet with counterparts at MFEP/MOH/DANAFCO to establish procedures for conducting regularly scheduled coordination meetings.	USAID/Kirkland MOH/DANAFCO	12/31/88
3. Arrange public and private sector training evaluations.	USAID/Kirkland	12/31/88
4. Arrange internal project review by all partners for completion of current project and in preparation for a follow-on project.	USAID/Kirkland REDSO/Holfeld	12/31/88
5. Organize Project Identification Document exercise (To take place in May 1989).	USAID/Kirkland	04/31/89
6. Work with REDSO to resolve disbursement reporting delays.	USAID/Towery/ Kirkland	12/31/88
7. Assist DANAFCO to develop stronger leadership for social marketing programs and upgrade marketing skills of DANAFCO staff.	USAID/Kirkland	12/31/88
8. Review and revise pricing structure for CSMP contraceptives.	USAID/Kirkland	01/15/88

(Attach extra sheet if necessary)

APPROVALS

F. Date Of Mission Or AID/W Office Review Of Evaluation: (Month) June (Day) 15 (Year) 1988

G. Approvals of Evaluation Summary And Action Decisions:

	Project/Program Officer	Representative of Borrower/Grantee	Evaluation Officer	Mission or AID/W Office Director
Name (Typed)	Dr. J.R. Kirkland	Dr. Joseph Adamafio	N/A	Mr. F. Gary Towery
Signature			N/A	
Date	<u>11-12-88</u>	<u>8-12-88</u>		<u>12/2/88</u>

ABSTRACT

H. Evaluation Abstract (Do not exceed the space provided)

The goal of this project is to slow population growth and at the same time improve the health status of mothers and children. The purpose of the project is to increase the voluntary use of safe, effective and appropriate contraceptive methods by Ghanaian couples. This is to be accomplished by making an adequate supply of contraceptives and family planning services available on a continuing basis through the existing delivery network of the Ministry of Health (MOH), and through the development of a Contraceptive Social Marketing Program (CSMP) in the private sector. This mid-term "process" evaluation of the project was conducted by a team of two Redso/WCA development officers and two outside consultants and consisted of a review of project files and interviews with public officials and private sector personnel involved in the project. The purpose of the evaluation was to review the management and technical aspects of both the public and private sector components of the project and to make recommendations to facilitate achievement of the overall project purpose. It was also intended to identify future project directions for a possible follow-on project. The major findings and conclusions of the evaluation are:

- o The project is either meeting or exceeding expected outputs in most areas and will likely succeed in achieving its purpose. Although some problems still exist, the project has already attained the outputs of a substantially improved MOH contraceptive logistics system, provided management and family planning training at all levels of the MOH, developed a nationwide contraceptive social marketing program with retailer training and advertising components, and launched a nationwide public/private sector family planning information, education and communication (IEC) program.
- o Due to the long development time during which dramatic changes occurred in Ghana's economic situation, many assumptions on which the project design was based proved faulty. However, design weaknesses were satisfactorily compensated for by extensively drawing upon A.I.D. centrally and regionally funded resources and integrating them with the bilateral inputs.
- o The progress to date supports the development of a follow-on project which relies heavily upon contraceptive marketing but with continued support for essential public sector functions.
- o In order to ensure greater institutionalization and long term sustainability of project initiatives the PACD should be extended 6-9 months.

The evaluation noted the following "lesson":

- o As the Project was restricted to family planning and USAID had no other bilateral health projects, the GOG perceived that A.I.D. was only interested in this particular intervention. Programming in the context of child survival would therefore be more acceptable to Ghanaian counterparts, and also more reflective of USAID's true intent. Future project designs should allow for a more integrated approach.

COSTS

I. Evaluation Costs

1. Evaluation Team		Contract Number OR TDY Person Days	Contract Cost OR TDY Cost (U.S. \$)	Source of Funds
Name	Affiliation			
Andrew Sisson	REDSO/WCA	40	12,000	REDSO/WCA
Joyce Holfeld	REDSO/WCA	30	9,000	REDSO/WCA
James Messick	ISTI Consultant	21	15,800	Project
Terry Mirabito	ISTI Consultant	21	15,800	Project

2. Mission/Office Professional Staff
Person-Days (Estimate) 10

3. Borrower/Grantee Professional
Staff Person-Days (Estimate) 20

A.I.D. EVALUATION SUMMARY - PART II

SUMMARY

J. Summary of Evaluation Findings, Conclusions and Recommendations (Try not to exceed the three (3) pages provided)

Address the following items:

- | | |
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| <ul style="list-style-type: none"> • Purpose of evaluation and methodology used • Purpose of activity(ies) evaluated • Findings and conclusions (relate to questions) | <ul style="list-style-type: none"> • Principal recommendations • Lessons learned |
|--|--|

Mission or Office: USAID/Ghana	Date This Summary Prepared: September 27, 1988	Title And Date Of Full Evaluation Report: Mid-term Evaluation: Contraceptive Supplies Project, Project No. 641-0109
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The primary objective of this mid-term evaluation was to review the management and technical aspects of both the public and private sector components of the project and to make recommendations to facilitate achievement of the overall project purpose. The evaluation also identified future directions for a possible follow-on project. In conducting the evaluation, the team reviewed project files and interviewed public officials and private sector personnel involved in the project. The report was initially drafted during March 1-17 and finalized in April 1988.

The project design was based on a number of assumptions: there was a positive policy climate for family planning program development in Ghana; the adverse economic climate had led to an increased desire for modern family planning services; approximately 30 percent of the population had access to services through the public health system; private retail sales outlets had almost no contraceptives for sale while public demand was considerable; there was a cadre of personnel trained in family planning who required only refresher training to upgrade their family planning skills; the MOH logistics system could absorb and utilize a continuing and expanded supply of contraceptives and could adequately distribute them; DANAFCO LTD could plan and implement all aspects of the Contraceptive Social Marketing Program (CSMP) with limited technical assistance; in general there was an unmet demand for family planning services.

Unfortunately, due to the time it took to develop and launch the project, and the very dramatic changes in Ghana's economy which occurred over this period, the validity of many of the assumptions was questionable by the time the Project Agreement was signed in September 1985. For example, in the private sector there were substantial stocks of diverted contraceptives in retail outlets, although supply was obviously irregular and not uniform. DANAFCO's physical capacity for contraceptive distribution was much less than anticipated. DANAFCO personnel managing the CSMP were not with the company when it distributed contraceptives provided by A.I.D. in the late 1970s. More important, DANAFCO's marketing expertise was limited and certainly less than assumed in the PP. In fact, there was no administrative analysis of DANAFCO in the PP, only DANAFCO's own statement of corporate capability.

Based on the assumptions of the project design, the principal inputs to the project were contraceptive commodities -- of \$7 million total funding, \$5.5 million was for contraceptives alone. All other project elements were funded at a low level. For example, project designers budgeted only \$80,000 for an intensive information, education and communication (IEC) component (plus another \$20,000 from a centrally-funded project).

To compensate for this situation the GOG and USAID significantly altered the mix of inputs so that project objectives could be attained. A large number of A.I.D. central and regional projects were tapped to provide resources in addition to those planned in the PP. These supplementary resources were targeted on weak areas in project design to compensate for faulty assumptions. Consequently, the project is considered on track, has major accomplishments, and is quite obviously achieving its purpose of increasing the availability of safe and effective contraceptive methods to Ghanaian couples, although it is too early to measure actual impact on contraceptive prevalence. By the end of the project it is estimated that access to contraceptives through a combination of government,

S U M M A R Y (Continued)

for profit, non-governmental (NGO's) and community based distribution outlets will be vastly improved. The USAID-funded Demographic-Health Survey (DHS) completed after the evaluation and to be followed by a Contraceptive Prevalence Survey in 1990, will provide some indication of the extent to which this target is being reached.

While the progress has been significant several major issues/problems have and are still continuing to affect the implementation of the project and the attainment of project outputs. Early in the project USAID assumed leadership in project management, which was effective for mobilizing project resources. Since then USAID has assumed a less aggressive leadership role and DANAFCO and MOH have increased their responsibilities. USAID recognizes that for long-term sustainability MOH and DANAFCO must assume greater responsibility and leadership in project planning and implementation. However, MOH's ability to manage project activities is influenced by its overall institutional capacity, which has suffered greatly from Ghana's prolonged economic difficulties. There are inadequate staff to carry out Ministry activities, and aspects of project management - including coordination, communications, and logistics - are often problematic. The MOH continues to have internal problems with respect to handling consignments of project commodities and clearing them from the port, thus requiring the Mission to devote considerable time and effort to ensuring project commodities reach the intended recipients within a reasonable time. DANAFCO's ability to plan and manage CSMP, particularly in marketing and use of information, is still limited and DANAFCO has yet to provide complete leadership and management for CSMP. For example, it provided only limited inputs for preparing the first marketing plan, and it is not adequately developing and using information about the market to carry out CSMP. Also, it has failed to provide strong guidance to its two sub-contractors for advertising and training.

An important objective for CSMP is to develop a largely self-financing contraceptive distribution network. This does not appear feasible by the end of the project in September 1989 because sales volume is still low, consumer demand was held back by an advertising ban, and contraceptive prices are low. The setting of prices has not been adequately examined by the various parties involved in the project, but it is an important issue that needs to be studied in the context of overall project priorities, i.e., increasing contraceptive prevalence while at the same time developing a self-financing CSM program.

Expenditures on project activities have not been reflected on financial reports issued by the REDSO/WAAC system. While approximately \$1.2 million has been expended to date for commodities which have already arrived in Ghana, only \$134,000 is currently reflected. USAID has been dealing with REDSO/WAAC to resolve this problem. Hopefully, with the arrival of a USAID controller this situation can be more fully addressed.

While problems do exist, they are not insurmountable. The evaluation team recommended that the PACD be extended 6-9 months to allow all objectives to be met. It was sufficiently encouraged by the project's progress to support a follow-on project that relies heavily on the private sector for contraceptive marketing but still supports essential public sector functions. It was felt that such a follow-on project should promote family planning as a child survival intervention.

LESSONS LEARNED

During the evaluation it was reiterated that USAID has focused on only one primary health care intervention, i.e., family planning, and that because of this USAID resources at times have tended to skew MOH priorities. It appears that programming in the broader health context with emphasis on child survival would be more acceptable to Ghanaian counterparts, and also more reflective of USAID's true intent.

ATTACHMENTS

K. Attachments (List attachments submitted with this Evaluation Summary; always attach copy of full evaluation report, even if one was submitted earlier; attach studies, surveys, etc., from "on-going" evaluation, if relevant to the evaluation report.)

Mid-term Evaluation Report, Ghana Contraceptive Supplies Project

Project No. 641-0109

COMMENTS

L. Comments By Mission, AID/W Office and Borrower/Grantee On Full Report

Overall, both the Mission and the principal Ghanaian counterparts felt evaluation was well done, that it addressed the relevant issues and followed the scope of work closely. Mission considered the duration of the field evaluation to be sufficient, however, the two A.I.D. officers on the team bore the brunt of the work in completing the final report, as the contributions of the two outside consultants were not in a finished state by their departure from Ghana. The Mission did not feel that the training evaluator had gained a good understanding of the training component of the project. As a result, the Mission considers this part of the evaluation to be the weakest.

Mission concurs with most of the findings and lessons learned, as they generally coincide with conclusions already reached by USAID staff and Ghanaian counterparts. In a few cases, however, the evaluation highlighted unforeseen issues which significantly affect project success, such as DANAFCO staff needing marketing training. In other cases both Mission and Ghanaian counterparts felt findings were not correct, or did not adequately consider background information provided to the evaluators. The most important of these concern the CSM program and USAID's role in project management. The issue regarding the development of a "self-financing CSM program" was misinterpreted to mean "completely self-financing", including being able to cover the cost of importation of contraceptive commodities. As stated in the project paper, and as pointed out to the evaluators by both the project officer and DANAFCO counterparts, "self financing" meant sufficient revenues would be generated to cover all costs assuming contraceptives were donated. The evaluation also states that the issue of contraceptive prices was not adequately examined. In fact, considerable time and research was devoted to establishing prices taking into account a broad range of factors such as the target groups, current prices of similar contraceptives in the market, etc. The recommendation that prices be examined more frequently and raised in small increments, however, is considered valid.

With respect to USAID's role in project management the evaluation implied that the USAID Project Officer's very active role may have resulted in his Ghanaian counterparts assuming less responsibility for project management. Considering the institutional weaknesses which were apparent at the time the project was being launched, both Mission and principal counterparts feel the project would not have made significant progress or achievements without the active participation of and management role played by the USAID Project Officer.

DANAFCO and USAID both reject the recommendation that DANAFCO should establish an advisory council for the CSM program with the MOH as host, as an (1) earlier attempt to do this had been unsuccessful, (2) the program is now well established and (3) no funding is available to cover associated costs. DANAFCO also prefers to upgrade its staff capabilities through local training rather than bring in a consultant for long periods.

From Mission standpoint, the evaluation highlighted a "lesson learned" other than that stated by the evaluation team. This concerned the fact that the design of the project should have been updated prior to its launch, as considerable time had elapsed since the original design was developed. This was especially significant since during the ensuing period profound changes occurred in Ghanaian society and the economy which resulted in many of the basic assumptions of the project design proving faulty. Such an update, therefore, would likely have led to a redesign with significantly altered inputs, and would have considerably reduced the management burden which was placed on the Project Officer and the Mission in trying to compensate for these faulty assumptions as they became apparent.

SUMMARY (Continued)

In general, Ministry of Health should be encouraged to design its comprehensive health program and to then ask the donors to support those aspects that are within their mandate (e.g, UNICEF for EPI and ORS, World Bank for infrastructure and facilities rehabilitation, UNFPA and USAID for family Planning). On the part of the host government this will require long-term planning, active government/donor interaction and increased donor coordination. USAID should present its contribution as part of the total plan.

MID-TERM EVALUATION

GHANA CONTRACEPTIVE SUPPLIES PROJECT

Project No. 641-0109

Evaluation Team

Andrew Sisson, Team Leader
Joyce Holfeld
Terry Mirabito
James Messick

April 1988

PROJECT IDENTIFICATION DATA

1. Country: Ghana
2. Project Title: Ghana Contraceptive Supplies Project
3. Project Number: 641-0109
4. Critical Project Dates:
Grant Agreement: September 19, 1985
Grant Agreement Amendment 1: March 27, 1986
Grant Agreement Amendment 2: March 31, 1987
Final Obligation Date: March 31, 1987
Project Assistance Completion Date: September 18, 1989
5. Project Funding (\$ millions):

AID Bilateral Funds:	\$7.0
AID Regional Funds:	1.0
AID Central Funds:	2.5
GOG Counterpart Funds	3.0
	<u>\$13.5</u>
6. Mode of Implementation:
AID Bilateral: Host country contract (DANAFCO) and USAID direct procurements
AID Regional: Operational program grant and buy-in to centrally-funded project
AID Central: Sub-agreements/sub-contracts under centrally-funded cooperative agreements or contracts
7. Project Designers:
REDSO Technical and Project Development Officers
Mission Program Staff
AFR/TR/HPN Personnel
Private Technical Consultants
GOG Officials
8. Responsible Mission Officials:
Mission Director: William Lefes, 1985-1986
Gary Towery, 1987-present
Project Officer: Ray Kirkland, 1985-present
9. Previous Evaluations:
Price Waterhouse Management Capability Assessment, October 1985

EXECUTIVE SUMMARY

The Government of Ghana (GOG) and the Agency for International Development (A.I.D.) approved the Contraceptive Supplies Project on September 19, 1985 with life-of-project funding of \$7.0 million over four years. The purpose of the project is to increase the voluntary use of safe, effective and appropriate contraceptive methods by Ghanaian couples. This is to be accomplished by making an adequate supply of contraceptives and family planning services available on a continuing basis through the existing delivery network of the Ministry of Health (MOH), and through the development of a Contraceptive Social Marketing Program (CSMP) in the private sector.

This mid-term evaluation's objectives are: review the management and technical aspects of the project, make recommendations to facilitate achievement of the project purpose, and identify future directions for a possible follow-on project.

The evaluation finds that despite faulty assumptions in the project design, the project is largely on track and has had major accomplishments. In the public sector, the project has contributed to significant improvements in the MOH logistics management and supply system, especially in its reporting. Other important improvements include: development and implementation of a plan of action for improving contraceptive supply management; increased supervision of family planning service delivery in the field, and training of personnel at all levels in data collection and analysis.

A pre-service education curriculum for nurses and midwives has been developed and much in-service training for MOH personnel at all levels (from central to local) has been completed, with more anticipated soon. Most of this training has been in Ghana, but useful training has also been completed in other countries, particularly Nigeria. This training stresses technical skills and management, which are both essential for improved family planning management and service delivery.

Exciting work is being done by MOH personnel in information, education, and communication, with various activities geared towards Ghana's decision-makers, family planning service providers, potential clients and current users of family planning, and the general public. Already there have been notable achievements, such as the holding of a national conference on Population and National Reconstruction, and MOH's aggressive strategy to promote interest in family planning holds much promise.

In the private sector, DANAFCO, a major pharmaceuticals manufacturer and distributor in Ghana, has been implementing CSMP under contract to the Ministry of Finance and Economic Planning (MFEP). DANAFCO has established a commercial wholesaler system in all ten regions of Ghana, and its retailer system now includes approximately three thousand pharmacies and chemist shops. Before supplying contraceptives to these retailers, DANAFCO provided training to them in family planning methods and use.

While these accomplishments are significant, there are management and technical concerns that should be addressed if project objectives are to be achieved. Early in the project, the A.I.D. Mission to Ghana (USAID) assumed leadership in project management, which was effective for mobilizing project resources. Since then USAID has retreated some in its leadership, and DANAFCO and MOH have increased their responsibilities. However, responsibilities and

leadership in project planning and implementation need to be shifted even more from USAID to MOH and DANAFCO.

MOH has not kept MFEP adequately informed about the project, which is one important reason for MOH not receiving previously agreed-to budget support for the project. Inadequate budget has caused a number of project activities to be postponed or cancelled, and for project-supplied contraceptives to be delayed in clearing the port. MOH coordination of project activities within the ministry has been lacking at times. Also, MOH gains achieved with project support in contraceptive logistics management and supply are fragile.

MOH's ability to manage project activities is influenced by its overall institutional capacity, which has suffered greatly from Ghana's prolonged economic difficulties. This means that there are inadequate staff to carry out ministry activities, including the project, and that all aspects of project management, including coordination, communications, and logistics are rendered problematic. The ministry has an important and legitimate complaint that the project's focus on family planning precludes project activities from being well integrated into the ministry and from helping MOH address other priorities as well. Given that project funds are required to be spent for family planning purposes, not much can be done to reorient this project towards a more integrated approach. But if there is a follow-on project, it should be designed to take this MOH concern into account.

DANAFCO's ability to plan and manage CSMP, particularly in marketing and use of information, is not as great as assumed in the project design. This helps explain why DANAFCO has not yet provided complete leadership and management for CSMP. For example, it provided only limited inputs for preparing the marketing plan, and it is not adequately developing and using information about the market to carry out CSMP. Also, DANAFCO has not provided strong guidance to its two sub-contractors for advertising and training. Hence, advertising efforts have been loosely focused and training has not been monitored or evaluated.

An important objective for CSMP is to develop a largely self-financing contraceptive distribution network. This does not appear feasible by the end of the project in September 1989 because sales volume is still low, consumer demand was held back by an advertising ban, and contraceptives prices are low. The setting of prices has not been adequately examined by the various parties involved in the project, but it is an important issue that needs to be studied in the context of overall CSMP priorities. Which is more important, increasing contraceptive prevalence (which implies lower prices for contraceptives) or establishing a self-financing system (which implies higher prices)? Underlying this issue is targeting of CSMP and MOH services.

These issues are not insurmountable, and recommendations follow which the evaluation team hopes will help the GOG, DANAFCO, and A.I.D. move the project closer toward its objectives.

The evaluation team is sufficiently encouraged by the project's progress to support a follow-on project that relies heavily on the private sector for contraceptive marketing but still supports essential public sector functions. The follow-on project should promote family planning as a child survival intervention, therefore allowing for a more integrated approach, and it should draw on existing networks in both the public and private sectors.

MAJOR RECOMMENDATIONS

1. MOH should keep MFEP informed about all public sector project activities through periodic reports and meetings. MFEP and MOH should meet to clarify what reporting requirements are necessary.
2. MFEP, MOH, DANAFCO and USAID should hold quarterly meetings to review the private and public sector components of the project.
3. USAID should seek ways to further shift responsibility for implementing and managing the project from the Project Officer and Cooperating Agencies to Ghanaians in MOH and DANAFCO.
4. MOH and USAID should independently and then together review the project's progress, taking a fresh look at project plans, budgets, achievements and difficulties. They should examine how individual project activities might be better coordinated, and they should develop an overall implementation plan and revised budget for the project.
5. MOH, with technical assistance from the project, should arrange an evaluation of all public sector training participants in order to identify strengths and weaknesses in knowledge and skills, and to measure impact of training.
6. DANAFCO should demonstrate strong leadership and commitment to developing and managing the entire Contraceptive Social Marketing Program, paying particular attention to marketing and use of management information systems.
7. DANAFCO, with USAID support, should recruit an experienced technical advisor who, during periodic 2-3 month visits to Ghana, would increase the knowledge and skills of DANAFCO's CSMP personnel, especially the Coordinator and Marketing Manager, and would assist them with: a) basic marketing; b) program development and coordination; c) use of management information systems; d) advertising and marketing research; and e) program planning, scheduling and reporting.
8. DANAFCO and MFEP should review the pricing structure for CSMP now and at least once each year as required by the MFEP-DANAFCO contract.
9. Prior to training more pharmacists and chemical sellers, DANAFCO should evaluate the course and proceed quickly with its plans to evaluate those who have already completed the training.
10. The GOG and USAID should consider designing a follow-on project along the lines suggested in section 5 of the report.

ABBREVIATIONS AND ACRONYMS

ACNM	American College of Nurse Midwives
A.I.D.	Agency for International Development
AID/W	Agency for International Development/Washington (headquarters)
AVSC	Association for Voluntary Surgical Contraception
CA	Cooperating Agency
CDC	Centers for Disease Control
CPS	Contraceptive Prevalence Survey
CRS	Contraceptive Retail Sales
CSMP	Contraceptive Social Marketing Program
CSP	Contraceptive Supplies Project
DHMT	District Health Management Team
DHS	Demographic and Health Survey
EPI	Expanded Program for Immunization
GOG	Government of Ghana
GNFPSP	Ghana National Family Planning Program Secretariat
HED	Health Education Division (MOH)
IEC	Information, Education and Communication
IERD	International Economic Relations Division (MFEP)
IMF	International Monetary Fund
IMPACT	Innovative Materials for Population Action
INTRAH	(Program for) International Training in Health
IPPF	International Planned Parenthood Federation
IUD	Intra-uterine Device
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
JSI	John Snow, Inc.
KAP	Knowledge, Attitudes and Practices
MCH/FP	Maternal Child Health/Family Planning
MSH	Management Sciences for Health
MFEP	Ministry of Finance and Economic Planning
MOH	Ministry of Health
ORS	Oral Rehydration Salts
PACD	Project Assistance Completion Date
PCS	Population Communication Services
PP	Project Paper
PPAG	Planned Parenthood Association of Ghana
PRITECH	Technology for Primary Health Care Project
PROAG	Project Agreement
RAPID	Resources for Awareness of Population Impacts on Development
REDSO	Regional Economic Development Services Office
RTPF	Return-to-Project Funds
SOMARC	Social Marketing for Change
SRN	State Registered Nurses
ST/POP	A.I.D. Bureau of Science and Technology/Office of Population
TBA	Traditional Birth Attendant
UG/Legon	University of Ghana (Legon)
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development Mission to Ghana
VSC	Voluntary Surgical Contraception
WAAC	West Africa Accounting Center
WFS	World Fertility Survey

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Annexes

- A Recommendations
- B Scope of Work for Mid-term Project Evaluation
- C A.I.D. Regional and Central Project Inputs
- D Persons Contacted

1. INTRODUCTION

1.1. Overview of the Project

The Government of Ghana (GOG) and the Agency for International Development (A.I.D.) approved the Contraceptive Supplies Project (CSP) on September 19, 1985 with life-of-project funding of \$7.0 million over four years, and they obligated \$2.18 million in incremental funding. On March 27, 1986 and March 31, 1987, the GOG and A.I.D. signed amendments to the Project Agreement (PROAG) which obligated \$3.0 million and \$1.82 million, respectively, to fully fund the project, and which made minor changes to the project description.

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

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

The PROAG states that the GOG and A.I.D. "intend that primary overall achievement of the project will be the provision of contraceptives to all consumers desiring them, while the principal secondary achievement will be an increased demand and use of contraceptives. In reaching these goals, the project will focus on the following five basic elements:

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

1.2. Evaluation Objectives and Methodology

The primary objective of this mid-term evaluation is to review the management and technical aspects of both the public and private sector components of the project and to make recommendations to facilitate achievement of the overall project purpose. This evaluation also identifies future project directions for a possible follow-on project. Annex B gives the evaluation scope of work.

The evaluation team reviewed the project files and interviewed officials and public and private sector personnel involved in the project and drafted this report during March 1-17. The team finalized the report in April. Despite this short period, it was possible for the team to discuss the project with numerous MOH, MFEP, and USAID/Ghana staff as well as with DANAFCO, pharmacists, chemical sellers, and others knowledgeable about family planning in Ghana.

The team gratefully acknowledges the support of MOH, DANAFCO, MFEP, and USAID personnel for carrying out this evaluation, and it hopes that this report will be helpful to all the parties involved in the project.

The evaluation team members were:

Joyce Holfeld, Population Officer, REDSO - family planning specialist

James Messick, Consultant - social marketing specialist

Terry Mirabito, Consultant - training specialist

Andrew Sisson, Project Development Officer, REDSO, Team Leader - management specialist.

2. ENVIRONMENT AND VALIDITY OF PROJECT DESIGN

2.1. USAID Involvement in Family Planning in Ghana

In 1969, the GOG adopted a far-reaching population policy. In response, USAID developed a strategy for population assistance which was directed toward building commitment in all sectors of government to implement the policy and toward improving the very limited access and availability of family planning. Over the 1970-80 period, USAID provided approximately \$17.0 million to support five bilateral and 19 centrally-funded projects. The most recent of these was a social marketing program which ended in 1980.

In 1980, an evaluation team assessed the impact of this population assistance and found: a) the training of large numbers of Ghanaians in family planning had strengthened the local capability to implement programs; b) family planning services were available in the urban areas, but few services reached the rural areas; and c) the management information system for family planning was deficient, making it impossible to quantify achievements or effectively manage the program. Based on this assessment, USAID made plans for a follow-on population project which built on the strengths of the system and addressed the weak areas.

The early 1980's witnessed a period of steep economic decline in Ghana and a worsening of U.S.-Ghanaian political relations. In 1983, USAID suspended bilateral development assistance to Ghana and limited its population assistance to contraceptive commodity procurement and participant training through A.I.D. regional and central projects. During the same period, Ghana experienced a mass exodus of physicians and other health personnel out of the public health system and out of the country. In addition, the country suffered from severe scarcities of most expendable supplies, drugs, vehicles, and gas, which virtually immobilized the health care system. Practically the entire MOH budget went towards paying salaries, which were grossly inadequate, and few funds were left for operations and delivering services. When the U.S. lifted its ban on development assistance to Ghana, it decided to proceed with the Contraceptive Supplies Project and dusted off the draft project design that had been prepared in 1982. As the staff in Ghana was skeletal, the Project Paper (PP) was updated by the A.I.D. Regional Economic Development Services Office (REDSO) staff from Abidjan and consultants. In other words, the revised PP was prepared by remote control with little input into the project design from Ghanaians or others with significant experience in Ghana.

2.2. Validity of the Contraceptive Supplies Project Design

The design of the project was based on a number of assumptions:

- there is a positive policy climate for family planning program development in Ghana;

- the adverse economic climate had led to an increased desire for modern family planning services;
- approximately 30 percent of the population have access to services through the public health system;
- private retail sales outlets have almost no contraceptives for sale while public demand is considerable;
- there is a cadre of personnel trained in family planning, requiring only refresher training to upgrade family planning skills;
- the MOH logistics system could absorb and utilize a continuing and expanded supply of contraceptives and could adequately distribute them;
- DANAFCO could plan and implement all aspects of the CSMP with limited technical assistance; and
- there is, in general, an unmet demand for family planning services.

Unfortunately, due to the time it took to develop and launch the project, and the very dramatic changes which occurred during the project development period, the validity of many of the assumptions was questionable by the time the Project Agreement was signed in September 1985. For example, while there was an excellent population policy, there was not, in fact, strong support for family planning program development, either within the MOH or within the Ghanaian Government in general.

MOH, while considering family planning important, gave it a low priority among its six targeted primary health care interventions. The media carried no positive statements by the government on its family planning program, and articles appearing in the press on family planning and contraceptives were generally of a sensational or derogatory nature.

In the private sector there were diverted contraceptives in retail outlets, although supply was obviously irregular and not uniform. The MOH contraceptive distribution and reporting system had deteriorated considerably between 1983 and 1985, to the point that only 4 of 10 regions regularly submitted reports on the contraceptives in their clinics. There was practically no family planning in-service training and the curricula of the nurse and midwives schools contained only a two hour lecture on family planning. There were only about 15 public sector nurses and one private sector midwife in Ghana who could insert intra-uterine devices and only one site where surgical contraception services could be obtained. The 11 centers which previously provided laparoscopy services had ceased to function, as had the laparoscope maintenance center.

The widely-held belief that a large portion of Ghana's population knew of family planning and basically approved of it appeared from all accounts to be less and less the case. Research conducted on this issue in 1985 and 1986 indicated that knowledge of individuals about family planning was generally shallow, especially with regard to contraceptive methods. There was more misinformation than correct information being disseminated, even by service providers. There was no on-going research of a knowledge, attitudes or practices (KAP) or contraceptive prevalence survey (CPS) nature, or on other aspects of Ghanaian fertility.

In the private sector, DANAFCO's physical capacity for contraceptive distribution was less than anticipated, as it had warehouses in only two of ten regions, even though it was reputed to have a significant commercial network in five of the regions. Further, DANAFCO personnel now managing CSMP were not with the company when it distributed contraceptives provided by A.I.D. in the late 1970s. More important, DANAFCO's marketing expertise was limited and certainly less than assumed in the PP. In fact, there was no administrative analysis of DANAFCO in the PP, only DANAFCO's own statement of corporate capability.

Based on the assumptions of the project design, the principal inputs to the project were contraceptive commodities -- of \$7 million total funding, \$5.5 million was for contraceptives alone. All other project elements were funded at a low level. For example, project designers budgeted only \$80,000 for an intensive information, education and communication (IEC) component (plus another \$20,000 from a centrally-funded project).

2.3. Project Revisions to Date

The project goal, purpose, and outputs have not been changed since the PROAG was signed. However, the GOG and USAID have significantly altered the mix of inputs so project objectives would be more attainable. In general, they have tapped A.I.D. central and regional projects to provide resources (supplied by U.S. public and private organizations -- "Cooperating Agencies") in addition to those planned in the PP. The GOG and USAID have targeted these supplementary resources on weak areas in the design, to compensate for faulty assumptions. For example, besides the \$100,000 budgeted in the PP for IEC, USAID and the GOG have obtained an additional \$545,000 in A.I.D. central and regional project funds for IEC activities. Annex C provides more details on which supplemental resources have been obtained for the project. The addition of these resources has significantly improved the project's prospects for success.

3. PROJECT MANAGEMENT

3.1. Ministry of Finance and Economic Planning

3.1.1. Role

Although the Project Paper and PROAG provide only cursory information on MFEP's role in the project, they indicate that its role includes: 1) signing a contract with DANAFCO for implementing CSMP; 2) providing budgetary support, including GOG recurrent budget and P.L. 480-generated counterpart funds; 3) approving MOH uses of return-to-project funds (RTPF) generated from contraceptives sales; and 4) monitoring the project.

MFEP is a budget and policy-making ministry. It delegates management of CSP and other projects to line ministries. However, MFEP monitors projects and wants to be kept informed by line ministries responsible for implementing projects. It can coordinate with other GOG agencies to help project implementation.

For CSP, the ministry has played a budgeting and monitoring role. It signed a contract with DANAFCO on March 27, 1986, and has received and reviewed quarterly reports from DANAFCO since then. It has provided counterpart funds to DANAFCO and MOH, and recurrent budget to MOH. It has approved no uses of CSP return-to-project funds for MOH because it has not received any accounting from MOH or the GOG Accountant General for these funds, even a summary total of how much exists. Except for budget requests and some discussions with MOH personnel, it has received no reports or other information from MOH on the project. MFEP personnel met with MOH and DANAFCO personnel more often earlier in the project, and worked with MOH and DANAFCO to get the ban on advertising lifted.

3.1.2. Contribution

According to the PROAG, MFEP is responsible for providing \$800 thousand in cedis from counterpart funds — \$300 thousand for DANAFCO and \$500 thousand for MOH. It is also responsible for providing recurrent budget for MOH staff salaries and operating costs, including port charges.

MFEP provided all of the counterpart funds to DANAFCO in one installment, about two months after the request was made. It provided a total of 11.5 million cedis in counterpart funds (approximately \$75 thousand) to MOH in two installments, following delays of at least three months in each case. Another MOH request for 3.8 million cedis, made in December 1986, has never received a response from MFEP, and another request for 25.6 million cedis, made by the MOH in August 1987, was still outstanding as of mid-March 1988. MOH has received part of its recurrent budget request, but not enough to cover port charges for this project.

3.1.3. Issues

Monitoring. MFEP has not been adequately informed by MOH on progress of the project's public sector component. It has received no written reports from MOH, nor any accounting for how counterpart funds have been spent for this project. Little dialogue has occurred between MOH and MFEP or USAID and MFEP on progress of the project. However, MFEP states that it receives little information from MOH on other projects as well.

On the other hand, MFEP's capacity to monitor this project is limited, as one desk officer, with no assistants or office support, is responsible for monitoring 22 projects of four donors.

Counterpart Funds. MFEP acknowledges that this is a problem for other projects and donors as well as for this project. Reasons given by MFEP for problems in approving counterpart funds requests for CSP include: MOH not providing accounts for its past expenditures of counterpart funds, MOH not providing information to MFEP on the project, MOH not submitting its requests to the proper place in MFEP (this is disputed by MOH and USAID), some admitted organizational problems within MFEP, and budgetary constraints of the GOG overall (partly stemming from IMF/World Bank restrictions on GOG expenditures). The last of these reasons cannot be overemphasized; cedi liquidity has been extremely limited. In addition, problems in provision of counterpart funds may stem from family planning not appearing to be a high priority of GOG leadership, which is not aided by MOH's lack of feedback to MFEP.

Coordination of Family Planning In Ghana. There are several agencies involved in family planning in Ghana in both the public and private sectors. They would benefit from coordinating with each other. The Ghana National Family Planning Program Secretariat (GNFPPS) was created under MFEP, and one of its important responsibilities was coordination of all family planning efforts in Ghana. Unfortunately, GNFPPS experienced some serious problems, and it is now moribund.

3.1.4 Recommendations

- 1) MOH should keep MFEP informed about all public sector project activities through periodic reports and meetings. MFEP and MOH should meet to clarify what reporting requirements are necessary.
- 2) MFEP, MOH, DANAFCO and USAID should hold quarterly meetings to review the private and public sector components of the project.
- 3) MFEP and USAID should meet to review the overall PL 480 agreement and use of counterpart funds for all projects, with the objective of unblocking funds and streamlining procedures (as is currently being discussed by MFEP and Canada).

4) MFEP, MOH, and USAID should endorse and seek to implement the following recommendation included in the "Legon Plan of Action on Population" (1986 Ghana National Conference on Population and National Reconstruction):

"The National Family Planning Programme be restructured into a National Population Commission representing the interests of both the public and private sector organizations, and that a Population and Human Resources Secretariat be established within the Ministry of Finance and Economic Planning to service the National Population Commission. Such a secretariat will only be a coordinating agency, while other agencies in both the public and private sectors implement programmes on population."

3.2. Ministry of Health

3.2.1. Role

The Project Agreement states that the Ministry of Health is responsible for implementing the public sector component of the project, and the PP indicates that project-supplied contraceptives are to be distributed through the existing MOH system. However, neither document mentions what MOH's responsibilities are for planning, supervising, and coordinating project activities. The documents suggest that these are more the responsibilities of the A.I.D. Project Officer.

In fact, the MOH has managed the public sector component, making good efforts to work with USAID and cooperating agencies (CAs) to plan and implement project activities. The Project Director is the MOH Deputy Director of Medical Services (Public Health), with responsibility for day-to-day management delegated to the Director of MCH/FP. Project activities in supply logistics/distribution, IEC, and training come under the Director of MCH/FP. However, other parts of MOH also provide support to the project. The performance of MOH and other parties in implementing each of the project activities is discussed in Section 4. The remainder of this section examines MOH management of the project in more general terms.

3.2.2. Contribution

The Ministry of Health is responsible for contributing manpower, service facilities, its existing systems, and budget (e.g. for port charges to clear commodities). These are not entirely under MOH control, however, as budget allocations are made by MFEP.

It was not possible for the evaluation team to determine how much recurrent budget has actually been allocated to this project. The GOG has provided only \$75 thousand to MOH in counterpart funds (from PL 480) of \$500 thousand agreed to in the PROAG. For this project, as for other MOH activities in general, provision of recurrent budget is problematic -- funds are received late in the year and are less than requested. For example, the MOH has not received adequate budget from MFEP to pay port

charges for project commodities, despite MOH written assurances to USAID early in the project to satisfy a condition precedent to disbursement. Inadequate budget has also contributed to understaffing of health centers in the regions.

3.2.3. Issues

Integration of Project Activities within MOH. While project resources are focused almost exclusively on family planning, the Ministry views this as just one of six priority areas in public health (e.g. expanded program on immunization (EPI), oral rehydration therapy (ORT)). It would like to see project activities integrated with activities in the other five areas. For example, MOH believes the project should train clinic staff in other priority areas in addition to family planning. MOH believes that family planning would be more acceptable to the public if it were presented as part of a package of interventions, rather than alone. However, A.I.D. is not permitted to use project funds, which are from the Population Account, for non-population activities. USAID has compensated to the extent possible by obtaining funds from other sources for health activities.

MOH Institutional Capacity. MOH's ability to manage the project must be considered in the context of overall MOH capacity to plan and implement health activities. This capacity has suffered from Ghana's prolonged economic difficulties, which led to large numbers of doctors and other trained personnel leaving the country, to budgetary and staffing shortfalls, and to tremendous infrastructural constraints (e.g., communications, transport, buildings for warehouses and clinics). An obvious consequence is that Ministry personnel at the higher levels, while dedicated and capable, have little support and are overextended. They have many responsibilities besides this project and little assistance to carry them out. MOH shortcomings in managing this project are therefore understandable. The World Bank is currently preparing a health sector assessment which hopefully will shed further light on this issue and will help MOH to make improvements.

Project Planning and Coordination. The Ministry of Health has not always assumed leadership in planning project activities. Also, MOH coordination of project activities within the Ministry has been lacking at times. These shortcomings derive in large part, no doubt, from institutional weaknesses mentioned above. They may also be due in some measure, though, to ambiguities in the PP and PROAG concerning MOH responsibilities, and the USAID Project Officer taking a very active role in project management. For example, owing largely to communications difficulties within the MOH, the Project Officer himself has promoted communications and coordination between different Ministry units.

Relations with MFEP. As discussed in Section 3.1., MOH has not actively informed the Ministry of Finance and Economic Planning about the project. It has provided no written reports on the project and has not accounted for past budget (recurrent and counterpart) spent on the project. Without better reporting, obtaining additional budget support from MFEP will continue to be problematic.

Donor Coordination. With numerous donors making many different demands on MOH staff, MOH implementation of its programs is often made more difficult. The UNFPA and USAID each having separate reporting requirements for contraceptives is only one example. Currently there are no donor coordination meetings. It would appear that some economies could be achieved if donor coordination were improved.

3.2.4. Recommendations

- 1) MOH and USAID should independently and then together review the project's progress, taking a fresh look at project plans, budgets, achievements, and difficulties. They should examine how individual project activities might be better coordinated, and they should develop an overall implementation plan and revised budget for the project.
- 2) MOH should seek ways to further increase its responsibilities for planning, implementing, and managing the public sector component of the project, including coordination of various activities within the MOH.
- 3) MOH should keep MFEP informed about all public sector project activities through periodic reports and meetings. MFEP and MOH should meet to clarify what reporting requirements are necessary.
- 4) MOH should more actively promote coordination among donors and the GOG in the health/family planning sector.

3.3. DANAFCO

3.3.1. Role

According to the Project Agreement, DANAFCO is responsible for implementing the Contraceptive Social Marketing Program. Its management responsibilities are specified in its contract with MFEP:

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

To varying degree, DANAFCO has fulfilled all of these responsibilities. With technical assistance provided by Social Marketing for Change (SOMARC), an A.I.D. centrally-funded project), it has managed the program, including developing a marketing plan which includes advertising

and promotion. DANAFCO has developed a distribution system which operates in all ten regions. Through a sub-contractor DANAFCO has trained pharmacists and chemical sellers as planned. With another sub-contractor DANAFCO has implemented advertising and promotion activities.

Further, DANAFCO has prepared and submitted financial and commodity reports to MFEP and USAID, although they lack some important information (such as depot-to-retail sales), and have often been tardy. It has also conducted periodic retail audits regarding inventories, storage, display, and retail sales.

3.3.2. Contribution

DANAFCO's planned contribution was to provide its experience and networks as a commercial distributor including warehousing, packaging, distributing, and marketing facilities and skills, including its 1978-80 experience as distributor in the Ghana Contraceptive Retail Sales (CRS) program.

DANAFCO provided its facilities as planned. DANAFCO expanded its distribution network to ten regions as agreed in its contract with MFEP. Two of the original five regional depots were DANAFCO's own facilities; depots and distribution in the northern five regions have been arranged by agreement with other commercial organizations.

DANAFCO has also provided enthusiastic, capable personnel to the program, including the program's Coordinator, who spends about fifty percent of his time on CSMP, and a full-time Marketing Manager. In addition, DANAFCO has hired a research director and recently an advertising manager for the company who devote substantial time to the program.

3.3.3. Issues

DANAFCO's Overall Development and Management of CSMP. An important assumption in the project design was that because DANAFCO was a successful distributor of products during the 1977-1980 Ghana CRS program, it could fill the same distributor role plus develop and manage the overall Contraceptive Social Marketing Program. This greater role includes: broad marketing program planning; development and management of subcontractors in market research, advertising promotion, and retailer education; and coordination of activities and reports on all aspects of the program. This assumption was largely unfounded, as many of these functions were quite new to DANAFCO. The Managing Director of DANAFCO and the CSMP Coordinator have no background in marketing, and none of the DANAFCO individuals responsible for this program were involved in the previous CRS program.

This faulty assumption has contributed to DANAFCO's not yet providing complete leadership and management for the program. For example, the marketing plan for CSMP was developed primarily by SOMARC, with only input from DANAFCO, and the plan's utility for CSMP management is now questionable since it is seen more as SOMARC's plan than as DANAFCO's.

Also, DANAFCO is not taking full advantage of its sales data to market contraceptives, and its marketing research is not responding well to CSMP needs. In addition, DANAFCO has not appeared to provide enough leadership to its two subcontractors, particularly in advertising.

CSMP Coordination. Although DANAFCO and USAID have met frequently, particularly early in the program, meetings with other interested parties such as MFEP have been infrequent and ad hoc. USAID invited several groups to attend a coordination meeting for CSMP, but most did not respond and the meeting did not occur. As a result of CSMP's not developing wider contacts, knowledge of the program has not been as widespread as it should be. For example, when the advertising ban was imposed by a high-level GOG authority, he reportedly did not realize that CSMP was supported by MOH and MFEP. Better coordination with many persons and organizations could promote positive, healthy development of CSMP and could also enlist more support for CSMP within Ghana. It might also reduce any misunderstanding about the program.

3.3.4. Recommendations

- 1) DANAFCO should demonstrate strong leadership and commitment to developing and managing the entire Contraceptive Social Marketing Program, paying particular attention to marketing and use of management information systems.
- 2) DANAFCO, with USAID support, should recruit an experienced technical adviser who, during periodic 2-3 month visits to Ghana, would increase the knowledge and skills of DANAFCO's CSMP personnel, especially the Coordinator and Marketing Manager, and would assist them with: a) basic marketing; b) program development and coordination; c) use of management information systems; d) advertising and marketing research; and e) program planning, scheduling and reporting.
- 3) DANAFCO, with USAID assistance, should have its CSMP Coordinator and Marketing Manager: a) visit successful contraceptive social marketing programs elsewhere (such as the Nepal CRS Company Ltd. in Kathmandu); and b) attend appropriate courses on social marketing, project development and management, and community-based distribution (such as at the Center for Population and Community Development in Bangkok, Thailand).
- 4) DANAFCO should review present CSMP personnel assignments and management structure. It should develop a personnel plan including incentives for program achievements. DANAFCO should give the Marketing Manager appropriately increasing responsibility for CSMP management.
- 5) DANAFCO should review its existing CSMP marketing plan, update and modify it as needed, and use it as a regular tool.
- 6) DANAFCO should establish a CSMP Advisory Council of 15-20 members to meet at least semi-annually and provide a regular forum for guidance, coordination, and support for the Contraceptive Social Marketing Program. MOH should chair the meetings with DANAFCO acting as

Secretary. Composition should include representatives from government and non-governmental organizations, professional associations, non-profit and commercial companies, and major family planning groups.

7) DANAFCO should modify its quarterly reports to include: depot-to-retailer sales, identification of all retail outlets, and data on retailers.

3.4. A.I.D.

3.4.1. Role

As described in the Project Paper and Project Agreement, the USAID Population Officer, as the Project Officer for this project, is responsible for coordinating all A.I.D. inputs, for monitoring the progress of both the MOH program and CSMP, and for assisting MOH and DANAFCO in resolving implementation problems. In addition, USAID must approve the MFEP/DANAFCO contract, as well as uses of counterpart and return-to-project funds. A USAID employee assists the Population Officer. In addition, the PROAG planned for a local assistant, to be paid from counterpart funds committed by the GOG to the project, to help the Population Officer and MOH in coordinating training activities. However, MFEP has since rejected this use of counterpart funds. The USAID assistant now handles much of the Mission workload related to training.

While not discussed in the PP or PROAG, AID/W's Population Office (Bureau for Science and Technology) and A.I.D.'s Regional Economic Development Services Office in Abidjan provide assistance to USAID. The AID/W Population Office helps procure contraceptives through its central procurement system. REDSO provides support for project implementation, such as providing technical, contracts, and legal assistance, and the REDSO Director must concur in certain implementation actions, such as issuing project implementation letters (PILs) to the GOG. The West Africa Accounting Center (WAAC), which is a part of REDSO, serves as controller for USAID, and must approve funding for A.I.D.-supplied inputs and maintain financial accounts for the project.

The project has clearly benefited from continuity in USAID project management. The USAID Population Officer arrived in Ghana a few months before the PROAG was signed, and he is expected to remain until Summer 1989. This highly motivated officer has taken an active role in the project, anticipated problems, and mobilized inputs so that the project could remain on track towards its objectives.

One of his most important accomplishments was quickly realizing that the project design included several faulty assumptions, and mobilizing resources from A.I.D. regional and central projects to overcome them. For example, the project's extremely limited attention to increasing Ghanaian knowledge of and demand for family planning was based on the incorrect assumption that this knowledge and demand already largely existed. The Project Officer therefore secured funding from A.I.D.

central and regional projects to secure technical assistance and other support for an IEC component from various cooperating agencies. While the Project Paper called for only employing 6 CAs, 14 have in fact been employed for the project (see Annex C for further details).

The Project Officer's insistence that short-term technical assistance from these CAs be consistent, i.e. that the same people keep coming back to Ghana rather than replacements, may have irritated some CAs. However, the evaluation team believes that his insistence was correct since it reduced the amount of time and effort necessary from MOH, DANAFCO, and A.I.D. for orienting new advisors. In addition, the Project Officer has closely monitored all project components, by insisting on being informed by all technical advisors provided by CAs, and by staying in close contact with MOH and DANAFCO personnel. He has also worked hard to promote coordination of project components.

USAID is very satisfied with the quality and responsiveness of REDSO assistance for this project. It has had minor difficulties with AID/W's support, as described below.

3.4.2. Contribution

In accordance with the PROAG, A.I.D. has obligated \$7.0 million in three tranches for the project. A.I.D. has earmarked \$3.2 million of that amount, but actual expenditures, as described below, are unknown to the Mission. By October 1988, A.I.D. will also have expended an estimated \$2.5 million from regional and central projects in addition to the \$576 thousand planned in the PROAG.

3.4.3. Issues

Level of USAID/Ghana Involvement in Project Management. The Project Officer has taken a very active role in the project, and done well in getting the project moving on track. However, at times he has taken too much of an implementation role that should have been MOH's or DANAFCO's. His efforts to identify and satisfy MOH needs and promote coordination have been productive, but they may, at times, have discouraged MOH from taking more of a role in assessing its needs and planning how to fill them, and more generally, from taking stronger leadership in the project. This may in part be due to a faulty project design process (see Section 2) which resulted in the PP's project implementation plan stressing A.I.D.'s role in implementation but being extremely vague about MOH's and MFEP's. On the other hand, in many areas the Project Officer is now less involved in implementation than before, since many inputs have been procured, CAs have been recruited, and their activities are now underway.

Project Planning. While the project activities (training, IEC, etc.) each have implementation plans, there is no overall implementation plan that could identify and resolve possible scheduling conflicts, eliminate potential duplication, and take advantage of economies. The Project Officer has effectively handled over two hundred visits to Ghana of

individuals and groups related to the project (primarily from CAs), not to mention many others related to his other responsibilities. Just while this evaluation team was in Ghana, advisors from five CAs also visited. At times these visitors, besides those from other donors, can put a strain on the few key Mission, MOH, and DANAFCO personnel. The scheduling and number of CA visits for the project is influenced by the fact that A.I.D. central and regional project funds are paying for much of the cost and that CAs have their own mandates, so the Mission, MOH, and DANAFCO have less control than if the project were paying ("buying in") for them. This is a price for mobilizing additional resources to support the project.

Counterpart Funds. As discussed in Section 3.1, availability of counterpart funds for the public sector program has been a problem. USAID and MOH personnel have been obliged to make numerous visits to MFEP to follow up on requests. As a result of delays in or not receiving this funding, training, IEC, and other activities have had to be postponed or cancelled. In many cases, A.I.D. regional and central project funds have been used to fill the gaps. The Mission is having difficulties in obtaining already agreed to counterpart funds for other projects as well. A reason for this may be that no special account has been set up for these funds.

Departure of Project Officer. The Mission Project Officer, who has been a strong force for this project, will finish his tour in Ghana in Summer 1989. The Mission will need a replacement, with well-developed skills in project design and management and strong technical skills in health and family planning, particularly in private sector service networks.

AID/W Support. AID/W has occasionally altered USAID contraceptives orders with no explanation to the Mission, and it has provided no information to WAAC or USAID on expenditures for contraceptives or project buy-ins to regional and central projects. Since contraceptives expenditures are by far the largest element of the project budget, it is impossible for the Mission to have an accurate picture of the project expenditures.

Project Documentation. USAID has issued only four project implementation letters for this project, the last one in April 1986 to notify the GOG that it had satisfied all conditions precedent to disbursement. Since then, A.I.D. has made a number of decisions that should have been better documented. For example, A.I.D.'s decision (WAAC's, in fact, but communicated as USAID's) to postpone contraceptives procurement until improvements were being made in the MOH contraceptives supply system was not communicated in writing to MOH, and no documentation on it could be found in Mission files. Given MOH's strong disagreement with this action, documentation is particularly important.

3.4.4 Recommendations

- 1) USAID should seek ways to further shift responsibility for implementing and managing the project from the Project Officer and CAs to Ghanaians in MOH and DANAFCO.

- 2) MOH and USAID should independently and then together review the project's progress and take a fresh look at project plans, budgets, achievements, and problems. They should examine how individual project activities might be better coordinated, and they should develop an overall implementation plan and revised budget for the project.
- 3) USAID and MFEP should meet to review the overall PL 480 agreement and use of counterpart funds for all projects, with the objective of unblocking funds and streamlining procedures.
- 4) USAID should start actively recruiting now for a qualified Population Officer to replace the incumbent, with at least two weeks of overlap before the incumbent's tour is completed.
- 5) USAID should immediately request AID/W to provide complete information to the Mission and WAAC on project expenditures for contraceptives and buy-ins to regional and central projects. With this information, the Mission and MOH should actively analyze and plan the entire project budget.

4. TECHNICAL PERFORMANCE

4.1. Public Sector Program

4.1.1. Contraceptive Logistics Management and Supply

A. Objectives

According to the Project Agreement (and elaborated in the PP), the project is to:

- fully supply contraceptive commodities (oral contraceptives, vaginal foaming tablets, IUDs, and condoms) to the public health delivery system; and
- to improve the commodities supply management and reporting system to ensure that a continuous supply of contraceptives will be available to all MOH facilities providing family planning services.

B. Accomplishments

In October 1985, USAID commissioned Price Waterhouse to determine the management capabilities of the project implementation agencies including the MOH. This assessment indicated that the internal controls of the MOH supply system needed to be strengthened and that supervision and project administration with regard to contraceptive commodity reporting and accountability needed improvement. Price Waterhouse recommended that before providing supplies to the public sector, major improvements in the contraceptive supply system be confirmed. Specifically, Price Waterhouse recommended: a) detailed reviews of existing inventory controls be carried out; b) measures to safeguard supplies from loss be introduced; c) project supervision and administration relating to supply management be improved; d) reporting be improved; and, e) a system for return-to-project funds be developed. As a result, WAAC determined that project funds could not be disbursed for contraceptives until there was demonstrated evidence that improvements were being made in the contraceptive supply system, including accountability for contraceptives.

In December 1985, USAID requested the Centers for Disease Control (CDC) to further assess the MOH contraceptive supply and reporting system and to develop practical recommendations for improvement. This assessment showed that the MOH contraceptive reporting system had deteriorated drastically with reporting completeness falling from 97 percent in 1983, to 68 percent in 1984, to only 43 percent in 1985. MOH, with assistance from Columbia University, developed and executed a nationwide sample survey to determine what contraceptive commodities were actually in the system. This survey further demonstrated the need to improve the contraceptive logistics supply and reporting system.

While MOH stated that it would work without USAID technical assistance or material assistance to upgrade the system, the December 1986 Price Waterhouse Review indicated that no improvements had been made.

In January 1987, USAID called on CDC and John Snow, Inc. (JSI) to provide technical assistance to the MOH to develop a comprehensive work plan and schedule to upgrade the contraceptive reporting system. MOH, with CDC/JSI assistance, reviewed the management information system, refined the reporting forms and procedures, and trained central level MOH supervisors in the use of the system. MOH began immediate action. From January 1987 to the present, MOH has followed the plan and made a concerted effort to improve the reporting system. MOH supervisors visited each region, district, and most health centers; reviewed, completed, and collected service statistics from all service sites; assessed the contraceptive inventories, removing outdated supplies and transferring overstocks to outlets with little or no stocks; provided supervision and on-the-job training to all levels of staff in how to properly prepare the contraceptive reports. The May 1987 Price Waterhouse Review indicated basic improvements in the system and the October 1987 review showed "significant improvements" in refinement of the system and in quality and timeliness of reporting.

In order to maintain the system and to ensure the continued timeliness and quality of reporting, MOH developed an action plan and in January 1988 conducted special training for 100 regional and district family planning coordinators (nurse supervisors) in the importance and use of the reporting system. These supervisors are now providing on-the-job training to Level B (polyclinics, health centers, and health posts) personnel. At workshops in March-April 1988, District Health Management Team (DHMT) supervisors will also begin providing 1-2 day focused training for Level B workers. This training will introduce a streamlined form which will no longer require Level B personnel to be responsible for reporting for USAID and UNFPA contraceptives separately but on a single form. Moreover, this new form will allow for greater accountability of revenues raised from the sale of both USAID and UNFPA contraceptives.

Because of improvements in the system, USAID ordered contraceptives (pills, condoms, and IUDs) in February 1987. These supplies arrived in the system in April 1987. Apparently one large shipment of condoms arrived in port in June 1987, but as the papers were lost the MOH has yet to clear the shipment from customs. The lack of condoms in the MOH system has impeded the delivery of services. USAID placed a second order based on procurement projections calculated in January 1988. For planning purposes, CDC/JSI also made contraceptive commodity projections until 1991.

USAID provided one vehicle for the MCH/FP division and five vehicles for the regional offices (UNFPA provided another five for the remaining regional offices) to aid in travel to and within the region to collect data, to provide better supervision, and to deliver contraceptive commodities. As of March 10, 1988, CDC and JSI had provided a total of four person-months of technical assistance for contraceptive reporting system development, refinement, and training. Also, PRITECH has provided a total of four person-months in the development of the overall MOH drug supply system. The MOH provided extensive central and regional staff time for refinement of the system and allowed considerable release time for staff training in the system.

In summary, the Contraceptive Supplies Project has made significant progress in meeting its commodity supply and management objectives. Major outputs have been:

- A plan of action for improving the contraceptive supply management and reporting system has been developed and implemented.
- The MOH supervisors have visited all regions, districts and health centers in an effort to improve the reporting system and assure availability of contraceptive supplies.
- The MOH has received and distributed new contraceptive supplies and has cleared all MOH shelves of expired contraceptives and redistributed overstocks.
- A training plan for improving data collection and analysis skills at all levels has been developed, and 100 regional and district supervisors have been trained.
- A streamlined reporting form for contraceptive supplies and usage has been developed which should reduce workload at all levels, allow all contraceptive (USAID and UNFPA) to be reported on the same form, and provide for much greater accountability of revenues raised from the sale of contraceptives.

The improvements in reporting will aid in decision making, targeting program expansion, evaluating program performance, and in accurately projecting contraceptive requirements.

C. Issues

System Sustainability. Although improvements have been achieved with respect to the contraceptive commodities logistics, the system at present is only where it was before 1984. Improvement is continuing, but the system is still fragile and will need additional technical assistance and monitoring. Further training, supervision, and monitoring will be required for the district level, B Level, and health posts. To the extent possible, record-keeping and reporting must be included as part of the regular in-service training of staff. Moreover, the efforts initiated to streamline the reporting system should continue.

USAID is cognizant of the fact that problems encountered in contraceptive supply go beyond the scope of the project and affect the entire MOH logistics system. To this end, USAID provided four person-months of technical assistance through the PRITECH project to assess the MOH logistics system and to make recommendations for an overall logistics improvement program, which included the contraceptive logistics. This study has served as a reference for MOH management planning as well as other donor planning. In the long term, continued technical assistance, training and planning will be needed to further refine the overall system for consolidated management of all MOH drugs, commodities, and supplies. MOH should proceed with executing the overall management logistics system for the MOH.

Contraceptive Requirements. CDC/JSI have developed contraceptive procurement tables and have estimated the contraceptive requirements to fully supply the public and private sectors through 1991. These requirements cost approximately \$600,000 less than originally budgeted.

Procurement of Contraceptives. As with all bilateral projects, contraceptives for the project are ordered through the AID/W central contraceptive procurement system. The system has offered flexibility in ordering and has reduced paperwork. However, some minor problems are noted in the system: the Mission is not always aware of the status of the orders on hand; it often does not receive timely or consistent documentation necessary for importation or tracking of goods; and supplies are back-ordered or sometimes quantities are altered without explanation.

Importation of Commodities. There are some bottlenecks in port clearances. The PRITECH study and USAID documentation indicate delays of 2-12 months from time of receipt of goods at Tema to final delivery to the MOH central warehouse. The main problem appears to be in the availability of MOH funds for port and delivery charges. Naturally, critical drugs have taken priority over non-essential items.

Distribution of Commodities. From the central level to the regional level the flow of commodities is smooth. From the regional to district B Level clinics, a "pull" system is in effect. In other words, the service providers have to pick-up supplies as needed. Lack of transportation is cited by the MOH as the major obstacle. The problem of transport is pervasive throughout the entire MOH service delivery system. USAID has attempted to assist with transportation by providing vehicles to 5 regions (UNFPA supplied the other 5 regions). Also, USAID has agreed to 25 percent of return-to-project funds remaining at the service level to aid in defraying transportation and other costs. USAID may want to consider supplying additional vehicles or spare parts to rehabilitate available cars in specific problem areas. However, in broader terms, the transportation problem is beyond the scope of this project.

Condom Supply. The MOH contraceptive monitoring procedures indicated that the MOH supply system was almost completely out of condoms in January 1987. USAID ordered condoms in February 1987 and apparently they arrived in port in June 1987. The MOH should immediately clear these commodities in order to stock the system which is in desperate need of these supplies.

The fact that one million condoms have been at the port since June 1987 and not yet been cleared by the MOH indicates a severe logistics and supply problem. Moreover, none of the recommendations made by the PRITECH report have been put into effect. Accounts of other donors as well as the experience of this project indicate that the MOH overall logistics system is not improving. Without a concerted effort on the part of the MOH to improve its comprehensive logistics management system, the efforts made by the project to improve the contraceptive logistics system are unlikely to have a long lasting effect, and in essence, will only be a band-aid approach to the problem.

Return-to-Project Funds. According to the most recent Price Waterhouse Report (October 1987), current MOH procedures for reporting and remitting sales proceeds require considerable improvements to ensure adequate safeguards against loss of sale revenues. Records indicate that most regions are either not reporting the sales revenues deposited in the Government Treasury, or else not depositing the proceeds. In addition, where deposits are made and reported, the amounts are not reconcilable to contraceptive commodities sold during specific reporting periods. This situation reflects a serious and continuing problem in financial accountability. This situation was also pointed out in the Price Waterhouse assessment conducted in 1985. Both MOH and USAID have attempted to get a better grip on these revenues and to establish a more effective accounting system, but little headway has been made in resolving the problem.

If the MOH wants to utilize these funds it is virtually impossible to access them once they are deposited into the Treasury. Price Waterhouse has made concrete suggestions for improvements in the return to project funds. Further study, technical assistance and a pro-active stance will be required by the MOH to rectify this situation. The financial management review that is to be conducted in June 1988 should investigate and make concrete recommendations regarding this problem.

D. Recommendations

- 1) The project should provide continued technical assistance to MOH to improve the contraceptive supplies system. MOH should continue to provide training, supervision and monitoring to ensure refinement and sustainability of the contraceptive logistics supply and reporting system.
- 2) MOH and USAID should reprogram excess funds in the contraceptive line item in order to support other under-funded or needed project activities.
- 3) USAID should communicate to ST/POP the problems it is experiencing with the A.I.D. central contraceptive procurement system and request timely status reports and proper documentation for contraceptive shipments.
- 4) MOH should take immediate measures to get the current condom shipment out of the port and into the public health system. On a long-term basis, MOH should improve its overall drug management and logistics systems to avoid this kind of problem in the future.
- 5) In the context of all financial issues, MOH should communicate to and resolve with MFEP the problems resulting from the lack of funds for port charges and the implication of poor financial accountability for return-to-project funds. USAID should request that these issues be reviewed during the upcoming financial management assessment.

6) MOH should take an active role in coordinating with multilateral and bilateral donors to seek a long-term solution to the vehicle/transportation problem. It should also explore alternative mechanisms to improve distribution of supplies (e.g., piggy-backing distribution of contraceptives with EPI supplies, utilizing private sector vehicles, retaining revenues at district and B Levels for transportation).

4.1.2. Training

A. Objectives

According to the Project Agreement (and elaborated in the PP), the project is to train personnel in family planning at all MOH clinics and in all community health service point being established under the impetus of Ghana's primary health care program. The training component is to:

- strengthen central and regional family health/family planning management capabilities;
- develop ten regional/district training teams; and
- provide direct training to health center teams (Level B) and community health workers and traditional birth attendants (Level A) in family planning service delivery and related technical skills.

B. Accomplishments

To meet these objectives, training has focused on pre-service education and in-service training. Training has occurred in Ghana, the U.S., and other countries. Cooperating agencies are providing technical assistance to MOH to address training needs in pre-service nursing education and in-service training. JHPIEGO has assisted with pre-service reproductive health education and physician training. Management Services for Health (MSH), INTRAH, Population Communications Services (PCS), the Centers for Disease Control, the American College of Nurse Midwives (ACNM), and the Association for Voluntary Surgical Contraception (AVSC) are providing technical assistance for in-service training.

Pre-Service Education. The main purpose of pre-service education is to include training in regular academic courses so that upon graduation service providers have the necessary skills and competencies to deliver high quality services. Seventeen nursing tutors and service providers, with technical assistance from JHPIEGO, developed a new curriculum in MCH/FP for implementation by all schools of nursing and midwifery throughout Ghana. The curriculum is currently under review by a board chaired by the MOH Director of Nursing and is slated for execution in february 1989. A total of forty tutors will be trained in comprehensive reproductive health to aid with a smooth transition to the new curriculum.

In-Service Training. The principal objective of in-service training is to improve the management, supervision, technical, and training capabilities of personnel at the central, regional, district, and health center levels, and to enhance technical capabilities of personnel at the community level. Training teams at the regional level are responsible for training the district health management teams (DHMTs) who in turn train and supervise Level B personnel. Level B personnel train and supervise traditional birth attendants (TBAs) and community health workers at Level A.

In 1985, the MOH, with the assistance of MSH and INTRAH, conducted a training needs assessment. They produced a master training plan which was designed to institutionalize in-service training through the development of management, supervision and training capabilities at the regional and district levels. Since that time, MOH has trained an array of service supervisors/providers: ten regional training teams of 3 persons each have been trained in management of primary health care, including family planning and training of trainers; 49 of a total of 69 DHMT's (284 persons) have been trained in three-week primary health care management and training of trainers courses; and 100 district trainers have been trained in family planning data collection with technical assistance from CDC/JSI. They are now training Level B staff. To support this management training, MOH, with technical assistance from WHO and USAID, developed a management training manual.

To further enhance clinical skills, 19 nurse-midwives, 9 of whom are tutors and 10 of whom are service providers, participated in a six-week course in family planning clinical skills at the University of Ibadan in Nigeria in July/August 1986. Since this training, four training sites have been established in four areas of Ghana. By April 1988, the 19 nurse-midwives will train in two-week workshops a total of 102 nurse-midwives--42 tutors and 60 service providers--in family planning clinical skills, including IUD insertion. The workshops include one week of theory and one week of practice. To date 9 tutors and 57 service providers have been trained. It is expected that one trained nurse-midwife capable of providing the full range of family planning information and services (including IUD insertions) will be placed in each Level B clinic.

To expand services to the rural areas, MOH, with assistance from UNICEF, ACNM and Columbia University, conducted a feasibility study and developed a training manual for TBAs. Under the auspices of a Columbia University operations research project, MOH has initiated a demonstration TBA training effort. Thirteen Level B trainers have been trained and now the next level of instruction is underway. This demonstration project will lay the foundation for a nationwide TBA effort, through which it is anticipated that approximately 6,000 TBAs will be trained.

In addition, with support from A.I.D. regional and central projects, 60 physicians and 47 nurse-midwives and educators have attended a range of short-term, U.S.-based or third country family planning-related courses.

C. Issues

Implementation of the Pre-service MCH/FP Curriculum. Implementation of the new MCH/FP curriculum in the schools of nursing and midwifery is crucial to the sustainability of primary health care services in Ghana. Currently State Registered Nurses (SRNs), Auxiliary Nurses and Nurse-Midwives are not well prepared to provide family planning services upon graduation from their respective schools. In 1969, MOH incorporated family planning into the curricula of the schools of nursing and midwifery throughout Ghana. The theoretical family planning component currently is now approximately two hours in length. The time allotted and the design of the student practica are inadequate to allow an opportunity for skills development. The new curriculum will be a major step forward in alleviating this deficiency.

Clinical and Communication Skills. SRNs and Auxiliary Nurse students rotate through two family planning clinics for eight days during their final year in school. Students observe service providers but do not practice during rotation. Upon graduation, SRNs and Auxiliary Nurses, particularly those assigned to rural areas, should be expected to provide basic family planning information services. If students are provided an opportunity to develop clinical and communication skills during their basic nursing education, they will be more confident and competent to deliver these services in an integrated fashion after graduation.

Insufficient Facilities for Clinical Practice. Two major constraints have been cited for the lack of adequate practica: 1) lack of qualified staff to provide training in the existing facilities, and 2) the unavailability of equipped facilities. The first constraint is being addressed by the training of tutors who will also practice part time, and by the training of service providers to precept students in the clinic. The lack of equipped facilities remains an issue, particularly as the demand for space is growing as nurse-midwifery students (and possibly SRNs) will now deliver family planning services during their clinical rotations.

Training Materials. At present, there is a dearth of teaching materials. The increased emphasis on MCH/FP in pre-service and in-service training has created a need for additional books and training materials.

In-service Follow-up and Trainee Evaluation. The level of effort expended by MOH central, regional and district staff in planning and executing the management and technical training for the district and health center levels has been high. Enthusiasm and support for training exist at the regional and district levels and the DHMTs are preparing to commence training of Level B staff in June. However, follow-up and evaluation of the training, trainers and trainees has not occurred. This has negated the opportunity to strengthen the training program based on feedback from trainers and participants and an assessment of the impact of the training.

Update Training. Trainers, originally trained in 1986 at the Ghana Institute of Management and Public Administration, have not received an update since then. In addition a review of the management and technical training curricula concludes that the trainers may require updates in contraceptive technology. The regional trainers now plan and coordinate training workshops, but they find it necessary to call upon resource persons to lecture on certain topics. Good trainers should be capable of planning and executing the training.

On-going Service Monitoring and Supervision. The supervisory system follows the same model as training, from central to regional to district to Level B to Level A. Monitoring and supervisory visits are conducted by a limited number of staff at the regional, district and health center levels. Lack of transport is constraining the development of a sustained supervision system, particularly from the district to Level B and to Level A. If family planning is to be integrated and sustained as a primary health care intervention, monitoring and supervision of all health providers must be developed and maintained. A competency-based performance checklist should be standardized and available for use in all districts.

Length of Training. MOH has planned training for family planning service providers in contraceptive technology and in clinical skills development. The Project Paper assumed that service providers would require an update in family planning rather than a basic course. This assumption may have been based on the fact that family planning was in the pre-service curriculum. However, a majority of the service providers have not received family planning services in their training and they lack basic knowledge and skills. As demonstrated by experience in other African countries, for service providers who are expected to initiate and provide a full range of family planning services (motivation, counselling, all methods including IUD, client management including side effects), two weeks of training may be insufficient for reinforcing knowledge and skills development. Similarly, for providers who are expected to provide all of the above services except IUD insertion, one week may be insufficient.

Training Coordination. Both pre-service and in-service training are initiated at a variety of levels. To ensure coordination of courses and consistency of content and to avoid unnecessary duplication, the MOH may want to better coordinate training activities. In this fashion, MCH/FP training, including the curricula and training materials can be standardized, and follow-up and evaluation of training and trainees can be streamlined. In addition, within the next year, it would be helpful for planning purposes if a training needs assessment could be conducted to identify additional training needs and to formulate an overall training plan based on MOH goals for primary health care.

D. Recommendations

- 1) MOH should take the necessary steps to ensure that graduates from the Schools of Nursing and from the Auxillary Nursing Schools are capable of providing counselling and a limited range of family planning services

(oral contraceptives, foaming tablets, condoms) upon graduation. To accomplish this the theory should be reinforced by skills development through clinical and counselling practica.

2) A team of nursing tutors and service providers should conduct a facilities survey to identify potential training sites and modifications necessary for providing MCH/FP practica. MOH should review this survey with USAID to determine possible project assistance, particularly in the area of equipment needs. MOH and USAID should also support the development, production and/or purchase of training materials and equipment for all technical schools and all in-service training sites.

3) MOH, with technical assistance from the project, should arrange an evaluation of all training participants in order to identify strengths and weaknesses in knowledge and skills, and to measure the impact of training. The evaluation should be planned at a time when training is in session so that observation of trainers may occur.

4) MOH trainers and coordinators should monitor and supervise all service providers including trainees on a regular basis. Factors which influence successful monitoring and supervision vary between regions and districts, thereby rendering one model for all regions inappropriate. MOH should convene quarterly district supervisors meetings to discuss alternative models and identify, in the process, factors which have facilitated performance with a view toward replication. A similar process should be conducted for Level B staff who have responsibility for supervising TBA's and community health workers.

5) MOH should consider lengthening the JHPIEGO-sponsored family planning clinical skills workshops to include 10 days for theoretical content and at least two weeks for skills development, including motivation of prospective clients. It should be understood by trainers and trainees that the completion of the practica is determined by competent performance of a specified number of procedures which may necessitate a longer practica.

6) MOH should request the project to send additional participants to the family planning clinical skills course at the University of Ibadan in order to support the further development of in-service training.

7) MOH should initiate coordination of all training at the central level. The project staff and national training coordinators should work with the deputy director of Nursing Education, all project training coordinators, and all individuals involved in training. This arrangement should attempt to develop or strengthen links among pre-service education and in-service training, as well as to enhance the quality of service delivery.

8) MOH should conduct a training needs assessment and develop a cohesive training plan.

4.1.3. Information, Education and Communication

A. Objectives

According to the Project Agreement (and elaborated in the PP), the project is to assure that potential clients and current users have accurate information upon which to make an informed decision regarding family planning. The strategy is to: a) inform potential clients of the availability of family planning services; b) recruit and maintain new clients; c) provide accurate information to new and existing clients and combat rumors and misconceptions about family planning methods; and d) educate males about the important family health benefits.

B. Accomplishments

The project designers assumed that there was a latent demand for family planning in Ghana. In fact, research shows a high awareness of family planning with over 60 percent of Ghanaians having heard of a modern method. Yet despite this apparent high level of awareness, contraceptive prevalence is estimated at only about 6-7 percent. Recent research suggests that the public is concerned about the safety and effectiveness of methods. Other obstacles to use of contraceptives include: negative attitudes of potential users; the lack of training and low motivation among service delivery personnel; the limited availability of audio-visual aids and support materials at service delivery points; and the lack of demonstrated commitment by key decision-makers. Given this "KAP-GAP," USAID decided to go beyond the original project design and develop a nationwide IEC program with approaches directed to four main target groups: decision-makers, service providers, potential or current contraceptive users, and the general public. To accomplish this, USAID has drawn on numerous A.I.D. regional and central project resources as the CSP was underbudgeted for this component.

Decision-makers. With funds and technical assistance provided by SOMARC, IMPACT and RAPID, the Regional Institute for Population Studies at the University of Ghana (UG/Legon) held, in April 1986, a national conference on Population and National Reconstruction. The Conference, with 200 senior level officials attending, offered a forum for frank discussions of issues concerning Ghana's population policy, particularly its family planning program. This meeting served as a springboard for UG/Legon to initiate other policy activities: notably a RAPID analysis of population growth and its implication for socio-economic development and a series of issue papers (three prepared to date) geared to decision-makers. The purpose of this activity was to regenerate top leadership interest and involvement in population program planning. UG/Legon has developed a popular version of the RAPID analysis for television, which has been shown to various GOG ministers and senior staff, and to influential groups in Ghanaian society.

Service Providers. To motivate public sector service personnel to provide accurate information and to encourage proper use of contraceptives, motivation and counselling skills and contraceptive updates have been incorporated into every type of service provider training. The MOH Health Education Division, with technical and financial assistance from Population Communications Services, conducted knowledge and attitude focus group research among family planning service providers to determine their perceptions regarding family planning. The results indicated that while service providers were generally favorable towards family planning, they lacked basic technical information and counselling skills. Consequently, MOH has provided training for 85 key health education planners and supervisors at the regional and district levels. The MOH has prepared a curriculum for family planning and IEC training. After a pretest in March of 1988, this five-day course will be replicated throughout the country to 1600 health service providers at the B Level. In clinical training, IEC has been incorporated in to standard curricula for in-service family planning training (JHPIEGO and AVSC). In expanding the pre-service curricula, the School of Midwifery is developing a strong motivation and counselling component into their three year curriculum. The MOH is developing materials to be used in supporting service providers in client education. Already it has developed and pretested a flip chart, a family planning reference booklet, and a general family planning pamphlet. These are being printed and will be distributed to public and private clinics by April 30, 1988.

Potential Clients and Current Users. Both the public and private sectors have taken an active approach to client recruitment. Coordination between the public and private sectors has resulted in the use of the same themes with consistent and reinforcing IEC messages. In the public sector, MOH is developing and pretesting six motivational posters for use in public places and health clinics. Two have been completed and are in printing. MOH has done initial development and pretesting of a brochure for pills, and plans are underway for the client brochures for the condoms and vaginal foaming tablets. MOH has assisted DANAFCO in developing and pretesting an instruction insert for the pill packets. It is developing a standard family planning sign to be placed in all public and private clinics to designate availability of services.

The General Public. To gain public support and to increase awareness regarding family planning, the Health Education Division has adopted an aggressive strategy for public education. MOH held a seminar for journalists and regularly submits information for press releases or news items. With the Ghana Broadcasting Corporation, MOH has developed two radio series: a talk show for general MCH/FP and a weekly drama series with health and family planning messages. MOH is planning a health education campaign geared toward males. MOH, with PCS financial assistance, is considering a folk media project which will disseminate information to the general public, particularly in rural areas, by local drama troupes and video shows.

PCS is the primary provider of technical and financial support for the public sector IEC effort. Up to March 1988, they have provided 36 weeks of technical assistance, funding for workshops for key MOH personnel and DHMTs, development of print materials, and overseas training for two Health Education Division staff members. IMPACT has provided six weeks of technical assistance, computer equipment and funds for development and dissemination of materials for policy-makers. SOMARC provided funds, technical assistance and funding for the 1986 National Conference on Population and National Reconstruction.

Excellent progress has been made by the project toward developing an effective nationwide IEC effort. A summary of major outputs of the IEC component are as follows:

- An improved MOH capability to plan, implement and evaluate IEC activities has been developed.
- An active public sector IEC strategy directed to policy-makers, clinic providers, clients and the general public has been developed and plan of action is in motion.
- Training curricula for in-service and pre-service IEC skills development have been designed and incorporated into various ongoing training activities. To date, 85 individuals have been provided with specific training in communication skills and plans are underway to train 1600 individuals at the B Level.
- A variety of print materials have been developed to support training, clinic services, community and public education, as well as for education of key decision-makers.

The project has already exceeded initial expectations in the IEC area. Moreover, the project has been instrumental in developing a greater awareness of the benefits of family planning as well as the options available for voluntary family planning. The strategy which MOH and USAID have chosen and the activities which they have undertaken are appropriate for the Ghanaian milieu.

C. Issues

Component Sustainability. MOH has assumed leadership in planning and implementing the public IEC activities. Project support has been devoted to the department's institutional development. The project should continue to train MOH health education staff, provide necessary equipment and transport, and financially support discrete IEC activities of this valuable resource. Assuming the availability of funds, the project may also work toward similar institutional development with other organizations involved in IEC such as GIMPA, the Ghana Broadcasting Corporation, and UG/Legon.

Policy-Level IEC. Although Ghana has had a population policy since 1969, additional measures need to be taken to ensure strong support for policy implementation. Without commitment of the various leadership groups,

rapid expansion of service delivery activities will be very difficult. To aid in the process of securing strong policy commitment, it will be particularly important for MOH and USAID to identify target policy audiences and to direct IEC messages to such leadership groups.

Over-Extension of Local Resources. MOH Health Education Division has matured significantly as the leader in the public sector IEC and nothing "breeds success better than success itself." The Division will have to expand staff and resources if it is to take on additional nationwide AIDS, ORT, EPI, and nutrition education campaigns. Caution will have to be taken to ensure that the Division does not become over-extended.

Service Availability. If all of the planned IEC activities are realized and they truly build a service demand, it will be extremely important for MOH to be sure that appropriate training and contraceptive supplies are in place in a timely fashion. Otherwise clients will be frustrated by lack of available services. MOH will enhance its creditability if high quality services are available to meet the demand.

PACD vis-a-vis Project Activities. PCS has a three-year plan of action to provide financial and technical assistance for the nationwide IEC effort. The plan of action is based on a consolidated budget of approximately \$830,000. The sources of funding for these activities are an A.I.D. central project (the PCS project with ST/POP), an A.I.D. regional project (the Family Health Initiatives Project), and bilateral (the Ghana Contraceptive Supplies Project). As each project's PACD is different, caution will need to be taken to be sure that the accounting by source of funding is maintained so PACD dates of each do not become a problem. Given the three-year IEC plan of action, it may be worthwhile for MOH and USAID to consider an extension of the PACD for the Ghana Contraceptive Supplies Project.

D. Recommendations

- 1) The project should continue to provide technical and financial support to build MOH's IEC technical capability and to expand institutional development activities with a variety of other communication resources, such as GIMPA, UG/Legon, and the Ghana Broadcasting Corporation.
- 2) MOH should encourage and the project should provide support for the further development of a strategy to build high level commitment for family planning services within the context of maternal and child health.
- 3) USAID and PCS should work with WAAC to determine a solution to the problem regarding the different PACD dates for the PCS activities.

4.1.4 Other Project Elements

Voluntary Surgical Contraception

A. Objectives

While no funding was provided in the project budget to cover the costs of voluntary surgical contraception (VSC), the Project Paper recognizes the need for such services and notes that the level of demand in Ghana is much greater than previously thought. It also indicates that such services were available in Ghana at some hospitals. At the time the project began this was no longer the case, as the physicians who had been trained to provide these services had either left public service or left the country. In order to ensure that such services were available to Ghanaians from both a health and family planning standpoint, and to lay the foundation for the development of a well-rounded family planning program with an appropriate method mix, MOH and USAID requested A.I.D. central project assistance from the Association for Voluntary Surgical Contraception (AVSC) in order to begin training physicians and nurse counselors and to reestablish VSC service centers in Ghana. The goal was to have centers re-established initially in the teaching hospitals, and once established, to begin expanding the number of centers to other regional and district hospitals. Once a sufficient number and spread of these facilities were in place, they were to be advertised as VSC centers through the IEC program of MOH, and would be linked with health centers and private maternity homes to receive their referrals. The goal of MOH, and one which USAID supports, is to have VSC services available at every regional and district hospital in Ghana.

B. Accomplishments

To date, an operating center has been rehabilitated in the two principal teaching hospitals in Ghana, and a physician/nurse team at each hospital has been trained in minilaparotomy and counselling. Services are being provided and demand is increasing. Plans are made for training an additional four teams in Nairobi and to begin training teams in Ghana at the teaching hospital in Kumasi. Present intentions are to add minilaparotomy under local anesthesia to these same centers currently providing laparoscopy services. As demand increases, additional physician/nurse teams will receive training both in Ghana and in third countries. AVSC and JHPIEGO will also provide support for seminars to public and private sector nurses and midwives who are expected to refer patients and clients for VSC and laparoscopic services.

C. Issue

Voluntarism Monitoring. As USAID has special, required monitoring and oversight responsibilities with respect to VSC projects, it must assure that the services are voluntary and that informed consent is documented. From all accounts, including USAID documentation and AVSC trip reports, this is being done. However, it was recently discovered that one of the centers could not readily locate its informed consent forms to go with its service provision records. The project director was informed both

verbally and in writing to either present the forms or else the project would have to be terminated immediately. The forms were found and are now being properly maintained with the surgical notes.

D. Recommendations

- 1) AVSC and JHPIEGO should continue to provide medical support to the MOH/VSC program to allow it to expand as demand warrants. They should also provide training in minilaparotomy with local anesthesia to private sector physicians who wish to offer such services if they have adequate facilities for doing so.
- 2) USAID and AVSC must continue to exercise vigilance in ensuring that all services provided are voluntary and that necessary documentation of this is adequately maintained.

Demographic and Health Survey

A. Objective

The PP indicates that one component of the project's final evaluation would be a contraceptive prevalence survey. In the PROAG (Amendment 2), this was modified by the GOG and USAID to be a Demographic and Health Survey (DHS), which was seen to be more relevant. It was also intended that the DHS be conducted at around the mid-point of the project. The DHS was originally viewed as a means for helping to determine the impact of the project on Ghanaian fertility. However, as MOH and USAID recognized most project activities would only be starting to take hold by the time of the survey, they decided that the DHS should be used as an up-dated baseline of fertility and contraceptive prevalence instead of relying on the 1979-80 Ghana Fertility Survey. The DHS would then be followed by a very focused CPS near the end of the project to be used for assessing impact and for the final evaluation.

B. Accomplishment

In carrying out the DHS, MOH and USAID requested assistance from an A.I.D. central project with Westinghouse. Westinghouse provided the necessary technical assistance and working with the Ghana Statistical Service (MFEP), it made the appropriate arrangements for carrying out the survey. Since the central project funds were limited, which would have severely restricted the sample size for the survey, DHS made arrangements with UNICEF and UNFPA to collect additional data for their programs in exchange for UNFPA providing supplementary funding for the survey and for UNICEF providing vehicles. These arrangements have made possible a nationwide survey of 4500 women of reproductive age with a sub-sample of males. The survey is currently on schedule in the field and should be completed by May 1988. Preliminary results are expected in the Fall of 1988, with the final report available by June 1989.

C. Issue

Timing of Follow-on CPS Survey. While the DHS will very likely form an excellent baseline for a follow-on survey to measure impact of USAID population assistance, the relatively short interval between the DHS and the proposed CPS will only produce limited results. An extension of the PACD might be considered to allow a sufficient time lapse. At any rate, the subsequent CPS should be a highly focused survey that can quickly but cost effectively measure project impact.

D. Recommendations

- 1) MOH and USAID should utilize the data from the DHS to the greatest extent possible to help shape the design of any follow-on project.
- 2) MOH and USAID should schedule the follow-on CPS as late as possible to allow for the most effective measure of project impact on contraceptive prevalence in Ghana.
- 3) MOH and USAID should ensure that DHS data are made widely available to other GOG/donor projects and activities. DHS data could be especially useful for training and IEC purposes.

4.2. Private Sector Program

4.2.1. Distribution and Availability

A. Objectives

According to the Project Agreement, the project is:

- to develop a largely self-financing contraceptive distribution network; and
- to develop an effective management supply system allowing for significant expansion of the retailer sales network resulting in improved consumer access to contraceptives.

B. Accomplishments

DANAFCO is to be commended for its establishment of a CSMP distribution network reaching all ten regions in Ghana. Before CSMP was launched in March 1986, DANAFCO had two of its own depots in the five southernmost regions. Since then, it has developed commercial wholesaler networks, including depots, in each of the other eight regions. DANAFCO's CSMP distribution system now includes approximately 3000 retail pharmacies and chemist shops. In checks in more than 30 shops in three different regions, the evaluation team found only one chemist shop that did not have some CSMP products on hand. CSMP vans are used well and are greatly helping distribution. Prior to the vans' use, retailers were expected to come to DANAFCO depots; now the products come to them. This network provides great potential for diffusing family planning throughout Ghana.

In addition, DANAFCO has begun to extend the CSMP network beyond urban areas. This includes using private sector midwives, whose training began in March 1988 with other project funds in coordination with the Ghana Registered Midwives Association, and a pilot study of market women in Accra, which is being coordinated by the National Council of Women and Development and by Columbia University.

Although CSMP accounts for only a small part of DANAFCO's total operations, DANAFCO is satisfied with CSMP and shows interest in continuing the program in the future. There are several benefits which are perceived by DANAFCO:

- CSMP uses capacity that would not otherwise be utilized. This was more of a factor before, when the state of the overall Ghanaian economy was extremely weak and had not yet started to improve;
- CSMP provides vehicles to DANAFCO which help with overall transportation for the company;
- CSMP holds the potential for increasing DANAFCO business through new contacts with the government and in the community;
- DANAFCO personnel are having their skills enhanced by program development; and
- the company itself receives favorable public recognition.

C. Issues

Development of a Self-financing Program. The development of a largely self-financing CSMP is not likely by September 1989. A reason for this is that the priority of the program is not clearly specified. Which is more important, increasing contraceptive prevalence (which implies lower prices for contraceptives) or establishing a self-financing system, capable of operating without donor support in the long term (which implies higher prices)? Contraceptives prices for CSMP were originally set in March 1986, and they are now very low. For example, many retailers are now selling condoms at more than 100% markup over DANAFCO's wholesale price. Although not specified in any GOG, DANAFCO, or SOMARC documents, there seems to be an understanding that MOH family planning services should reach the lowest socioeconomic classes and that CSMP's should reach the groups above. Experience from contraceptive retail sales programs in other countries indicates there is a tradeoff between widespread accessibility of contraceptive products at low prices and attaining a self-sustaining program in ten years or less. Evidence from other contraceptive social marketing programs suggests that waiting too long to increase prices, and then compensating by making large increases, can be harmful. This pricing issue has not been analyzed for Ghana's program.

D. Recommendations

- 1) DANAFCO, MOH, MFEP, and USAID should confirm the target population for CSMP after considering the target populations of other Ghanaian organizations involved in family planning (including MOH, the Planned Parenthood Association of Ghana, and the Christian Council).
- 2) DANAFCO and MFEP should review the pricing structure for CSMP now and at least once each year as stipulated in the MFEP-DANAFCO contract.
- 3) An independent firm should assess financial aspects of CSMP, including the issue of self-financing, and it should submit recommendations on achieving self-financing.
- 4) DANAFCO should test prices of products prior to making national pricing decisions.

4.2.2. Marketing

A. Objective

As stated in the Project Agreement, the project is to increase consumer awareness of available contraceptive products as part of product advertising, promotion and marketing activities.

B. Accomplishments

With its sub-contractor, Lintas Ghana Ltd., DANAFCO launched an advertising campaign in early 1986. Unfortunately, the campaign was stalled by an advertising ban imposed by the GOG from June 1986 to July 1987. This advertising ban was ended through the coordinated efforts of DANAFCO, MOH, and MFEP.

Since the ban was lifted, DANAFCO has been cautious in its advertising in order to prevent CSMP from being derailed. DANAFCO has aired radio commercials for CSMP after 9 p.m., and it has produced and displayed posters for two of its contraceptive products ("Kamal" vaginal tablets and "Panther" condoms) in many retail outlets. DANAFCO is also planning advertising with newspapers, billboards, and metal plates (store signs). All this advertising has been approved by the Ghana Pharmacy Board. In addition, DANAFCO has provided packages for Kamal tablets.

C. Issues

Motivation. DANAFCO has achieved contraceptives availability, but the sales trends of all three products are not in an upward swing. The next and most important marketing task is to stimulate demand. A stronger message appeal campaign is needed to build consumer motivation, sales and use.

Advertising Capabilities. CSMP has had difficulties in advertising and promotion. Lintas was thought to be a "full service agency" with all the requisite capabilities. However, Lintas's efforts were loosely focused and inadequate. Advertising schedules were not always kept, which resulted in marketing "gaps" or weak areas in the marketplace. At times, it seems that DANAFCO itself was not clear and definitive in its advertising objectives and in managing the Lintas subcontract. DANAFCO decided not to extend its contract with Lintas and has recently hired its own advertising manager to do in-house work and select/manage subcontractors. However, technical assistance is needed to: 1) help DANAFCO improve its ability to use its marketing plans, resources, and information, and to communicate its needs clearly to any advertising supplier; and 2) help DANAFCO develop a strategy for developing additional choices for subcontracting of advertising and promotion work.

Market Research. CSMP management needs to be more informed about the market situation and how its products are faring. Unfortunately, the research unit in DANAFCO has not served DANAFCO's marketing needs well. While the unit has excellent scientific research capabilities, it lacks the capacity to undertake quick and responsive consumer market research in the environment of a commercial distributor firm. On the other hand, DANAFCO management needs to provide more guidance to the research unit about what research should be done.

Packaging and package inserts.

a. Norminest. There are many Norminest loose cards which DANAFCO has sold to pharmacies and chemist shops. During store visits, it was observed that some of the blue Norminest pills are lighter color than others, which might indicate a change in efficacy. Furthermore, the loose Norminest cards now in the market have no instructions. Packaging would provide: 1) product protection, 2) a means for including instructions and warnings, 3) consumer attraction, and 4) a means for displaying the price. New packages and packaging inserts with many verbal and nonverbal instructions are nearly ready and need to be used for all Norminest pills.

b. Kamal. A new, smaller Kamal package is being designed which will contain 8 tablets instead of 12. This is a smart choice because the present pack is too large to fit in a pocket, because a pack of 8 tablets more closely represents a one month supply than 12, and because the smaller packet and an appropriately lower price should fare better against the competition. The quality of the present Kamal pack is marginal as it lacks a bright color and the printing is diffused and dull.

c. Panther. Panther is not packaged and thus no instructions can accompany the product. The "dispenser" is the standard A.I.D. box of 100 with a printed overleaf. The favorable aspect of this approach is that no packaging costs are incurred and that the Panther logo is nevertheless present on each of the 4 condoms in the strip. However, condoms may dry out more quickly than they would if there were some outer protection. In some cases, the strips also get dirty and dusty when loose. If there were to be a pack, a box would be the most expensive choice. An

alternative might be a plastic packet, in the same shape as the 4-unit strip, with instructions inserted and then an overlap closed and sealed. However, a decision on packaging should not be made until the following questions are answered: 1) Are the Panther condoms being damaged from not having an outer package? 2) Is damage coming from electrical light in the shop, from heat, from the sun? 3) How do Ghanaians feel about the present Panther strips of four presentation? 4) To what extent would an outer package generate greater sales? 5) Can damage be avoided by educating retailers to keep the Panthers inside the Panther dispenser and not display them under glass cases in sunlight or electrical light?

D. Recommendations

- 1) DANAFCO should devote greater efforts to developing, testing, and implementing message appeals in a well-coordinated campaign which will aggressively market the product.
- 2) DANAFCO should place notices in the press requesting that agencies, individuals and/or groups with consumer advertising and promotional experience send a summary of their education, training, and experience to DANAFCO. This may identify further candidate agencies or individuals for CSMP in the future.
- 3) To keep abreast of market changes, DANAFCO should conduct a regular monthly distribution check in at least Accra. It should visit 50 shops each month in a regular fashion, checking for inventory, competitive products, prices, and general comments from the shop sales people. DANAFCO should also ask its salesmen to obtain simple market information when they are in the field.
- 4) DANAFCO should investigate new options for conducting market research. It should utilize the services of its research director to evaluate, select and develop market research personnel or groups for CSMP.
- 5) DANAFCO should immediately package all Norminest pills, including the instruction insert. When the package and insert are ready, DANAFCO should replace all discolored Norminest cards with the new package and return the discolored cards to headquarters for disposal. The remaining good loose cards should also be packaged.
- 6) DANAFCO should take advantage of the Kamal packaging change to improve the color and printing quality, and perhaps also the graphical image. DANAFCO should also investigate the packaging of condoms.

4.2.3. Private Sector Training

A. Objectives

As indicated in the Project Paper, the CSMP training program is to provide up-to-date and authoritative training and information to retailers in the CSMP network in order to: 1) improve individual retailer performance and provide better service to the community;

2) better equip the retail sales network with the means to respond to consumer demand; 3) create/strengthen the capacity of retailers to present a credible case for the role of modern contraceptives in child spacing and family health; 4) assist retailers in such matters as marketing and promotion including the proper storage and display of the contraceptive products; and 5) provide pharmacists up-dated knowledge on contraceptive methods to permit counselling to customers.

B. Accomplishments

Under a sub-contract with DANAFCO, PharmaHealth has trained 2,850 chemical sellers and 250 pharmacists. A manual for chemical sellers and pharmacists, developed with technical assistance from SOMARC, was developed and provided the information for the training curriculum. The training course is one day and is free to participants, including lunch and transportation. Training methods reflect participatory techniques. Evaluation of participants is accomplished through role play. Upon completion of the course pharmacists and chemical sellers receive the training manual for reference, along with a free starter supply of contraceptives from DANAFCO. They also receive a check-list of contraindications and side effects, which they are to prominently place in their shops for reference by sellers and consumers.

An unexpected benefit of the chemical sellers training is that it appears to have contributed to a group consciousness, and encouraged them to create their own trade association. This new association could facilitate future training and outreach by DANAFCO and other suppliers, as well as by MOH.

In addition, the project, with supplemental funding from the A.I.D. regional African Manpower Development Project, has provided training to thirty private midwives in family planning clinical skills at the University of Ibadan. Another 100-150 private midwives will be trained in-country with technical assistance from the American College of Nurse Midwives. DANAFCO will provide training to these midwives on CSMP and will give them a one-time starter supply of contraceptives without charge upon completion of their training.

C. Issues

Evaluation of the Training Course. On average, pharmacist and chemical seller trainees scored about 20 percent on a pre-course knowledge test and about 80 percent immediately after the course, which suggests that the one-day course is having some success. However, it is impossible to judge since the training program has not been monitored or evaluated for content, process, or methodology.

Monitoring of Trainees. There has been no follow-up of those pharmacists or chemical sellers who have completed the course, so it is uncertain how much information they have retained and are correctly imparting to consumers. However, in visits to pharmacists and chemical sellers who participated in the training, the evaluation team observed some who sold oral contraceptives without screening clients. Another pharmacist

visited gave erroneous directions for taking oral contraceptives. In a number of shops the checklist was either not displayed prominently or not at all. Chemical sellers are supposed to refer first time acceptors of oral contraceptives to a physician or MCH clinic for an evaluation prior to selling the pills, and they are to screen acceptors prior to resupplying them with oral contraceptives. The extent to which these criteria are met may determine whether or not MOH will allow chemical sellers to continue supplying orals in the future.

Other Staff in Trainees' Shops. Although an impressive number of pharmacists and chemical sellers have been trained, there are other people working in their shops who have not been trained but are still selling contraceptives. Often these other staff have not received adequate information from the trainees, as indicated by two sons of a trained chemist who did not have correct knowledge about oral contraceptives and did not know that useful information was contained in the oral contraceptives checklist that was prominently displayed in their store.

D. Recommendations

- 1) Prior to training more pharmacists and chemical sellers, DANAFCO should evaluate the course and proceed quickly with its plans to evaluate those who have already completed the training. The evaluation strategy should include: selection of an appropriate sample of trainees; giving the selected trainees a questionnaire to test their knowledge of contraceptives technology; and employing mystery shoppers who would be directed to purchase contraceptives and report on retailers' client screening and instructions for contraceptives use.
- 2) Following evaluation of the course and trainees, DANAFCO should modify the course if necessary and establish and implement procedures to monitor trainees.
- 3) DANAFCO should devise and implement a plan for educating other staff in the shops of trained pharmacists and chemical sellers.

5. FUTURE DIRECTIONS

While it is too early to assess the project's actual impact, indications are that the project will succeed in achieving its purpose of increasing the voluntary use of safe, effective, and appropriate contraceptive methods by Ghanaian couples. CDC estimates that the project through 1989 will lead to a contraceptive prevalence rate of 15 percent. The distribution of family planning by source is estimated to be 20 percent by the MOH, 50 percent by the commercial sector, and 30 percent by non-governmental organizations. The share of family planning services delivered by the commercial sector is attributable almost entirely to the project's CSMP. Continuation of the current efforts and the expansion of services in the private sector could conceivably push prevalence rates to as high as 30 percent by 1994. This result would lead to a more measurable reduction in Ghana's annual population growth rate and to a reduction in the high infant and maternal mortality rates. Therefore, the evaluation team recommends that MOH and USAID proceed to develop a follow-on project.

5.1. Project Strategy

The team recommends that the follow-on project be developed with family planning as a child survival intervention. Repeatedly during the evaluation it was reiterated that USAID is focused only on family planning. It appears that programming in the context of child survival would be more acceptable to Ghanaian counterparts, and also more reflective of USAID's true intent. This is not to say that the team is recommending a primary health care project or a multifaceted focus, but that the design should allow for a more integrated approach. For example, the social marketing network could include other products (oral rehydration salts, malaria prophylaxis), training could be geared to include multiple interventions, and IEC efforts could include multiple messages. USAID has already initiated activities along these lines in the areas of oral rehydration salts marketing and infant weaning foods, drawing on other A.I.D. projects.

MOH should be encouraged to design its comprehensive health program and to then ask the donors to support those aspects that are within their mandate (e.g., UNICEF for EPI and ORS, World Bank for infrastructure and facilities rehabilitation, UNFPA and USAID for family planning). On the part of the GOG, this will require long-term planning, active GOG/donor interaction, and donor coordination. USAID should present its contribution as part of the total plan.

5.2. Project Approaches

Selected Support to the Public Sector. To maintain a positive policy climate and service delivery momentum, the follow-on project should carefully focus support on selected governmental efforts, particularly in the areas of policy definition, setting of service standards, standardization of systems (curricula, record keeping, IEC messages, etc.), and program coordination. With the training and system development that has taken place under the current project, many of the

activities should become institutionalized within MOH. Follow-on project inputs should also focus on demonstration or extension of innovative service delivery approaches to reach the rural population, utilizing, for example, traditional birth attendants or public sector community-based workers.

Extension of the Private Sector Social Marketing Networks. Most of the project's resources should focus on the private sector. Worldwide experience has shown that, with strong management, the private sector can deliver cost effective and quality services to diverse population groups in a short period of time. The current project is developing a number of commercial and "for-profit" networks, but the social marketing concept can be further expanded to include a number of other delivery networks. Possibilities include professional associations (e.g., physicians, teachers, nurses), trade associations (e.g., taxi drivers, truckers, beauty operators), other commercial channels (e.g., beauty product distributors), traditional channels (e.g., traditional chiefs, traditional herbalists), industrial settings (e.g., factory clinics, workplace distributors), and church groups (e.g., mission hospitals, prayer groups). It may be possible to market other products, such as oral rehydration salts, medicines, and other health aids, through these other delivery networks as well.

Use of Existing Networks. In both the public and private sector, the project should not create new institutions but build activities around existing networks. For example, in the public sector, existing networks might include teachers/educators, police and military personnel, agricultural extension agents, social service personnel, and community development workers. In the private sector, non-governmental and private voluntary organizations and mission health structures can be utilized. In this process, it is important that there be a strong coordination mechanism, and perhaps this is where the proposed national population commission can play a major role.

Extension of Services to Rural Areas. Under the current project, the commercial distribution focuses primarily on the urban population; the public sector is to reach the rural areas by training of traditional birth attendants and community health workers. As 70 percent of the population lives in the rural areas, it will be important for any future program to push services to this population by alternative means. This might be accomplished with social market approaches that utilize rural village level networks, such as traditional birth attendants, traditional herbalists, and village traders. Also, community-based distribution may be developed by recruiting and utilizing established village-level distributors such as chiefs and village elders, teachers, community health and development workers.

Program Sustainability. In the follow-on project, every effort should be made to build program sustainability. In the public sector, continuing efforts should be made to include training in all pre-service curricula for physicians, pharmacists, nurses, midwives, agricultural extension agents, and teachers. Emphasis should be on building competency based pre-service training rather than on "catch-up" skills training.

Supervision and monitoring systems should be strengthened so that those who have been trained will maintain and upgrade their skills. In the private sector, it will be important to encourage the development of self-financing distribution systems, making sure that profit margin is attractive and that groups receive either monetary gains or recognition to make the effort worthwhile. It will be essential to examine the trade-off between contraceptive prevalence and self-financing, taking a close look at target populations.

Project Implementation. The design of the follow-on project should pay much more attention to implementation than did the design for the current project. Implementation responsibilities, especially for host country personnel in both the public and private sectors, should be carefully defined. It should be clear that host country personnel are responsible for planning, executing and managing the project. Host country personnel should also be team members for follow-on project evaluations. A.I.D.'s role should be one of assistance with procurement of A.I.D. inputs, of facilitating and overseeing quality of AID technical inputs, of monitoring to assure that the project is on track towards its objectives, and of providing technical assistance and facilitating in problem resolution as required.

The project design should also consider procurement options which simplify project management, narrow the span of implementation control, and give host country and USAID personnel easier management control. A possibility is one or two institutional contracts under which all inputs are provided. If the design warrants the use of cooperating agencies, sufficient funds should be allocated to the project to allow full buy-ins to the appropriate centrally-funded project. This action would permit greater mission control over CA activities. For any institutional contracts, including host country contracts with private Ghanaian firms, competition, with requests for proposal, is recommended to encourage creativity and strong implementation.

5.3 Project Design Process and Timing

Process. In order to avoid the same mistakes made in the design of the last project, it will be particularly important to prepare well for the design of any follow-on project. Given that the follow-on project will fall within the next Country Development Strategy Statement (CDSS) exercise, the evaluation team recommends that a sector analysis be conducted and that a population/family planning strategy be developed. The evaluation team recommends early and extensive involvement by Ghanaian public and private counterparts in planning future project interventions. This involvement should start now with any modification of the current project, as well as with the sector assessment and with the development of a country population/family planning strategy. It may be appropriate for a formal GOG/USAID project review committee to be established which meets periodically to develop and review plans for the follow-on project. In addition, the team recommends that small operations research-type projects be developed to test the feasibility of implementing certain service delivery activities, such as was done in preparation for the TBA training. In order to make sound design

decisions, the team also recommends that major issues such as targeting and institutional capability of public and private sector implementors be thoroughly investigated prior to the actual design exercise. During the strategy development, specific issues to be explored should be identified.

Timing. The current Project Assistance Completion Date is September 18, 1989. The project appears to be on track in most areas, and actually making greater headway than expected in some. However, from the standpoint of greater institutionalization and long-term sustainability of project outputs, MOH and USAID may want to seriously consider an extension of the PACD. Justifications for this extension are: 1) additional time may be needed for full realization of project outputs (e.g., IEC program execution, training of TBAs, etc); 2) additional time may be needed to show project impact between the DHS survey and the impact contraceptive prevalence survey to be conducted as part of the final evaluation; c) additional time may be needed to implement several of the recommendations of this evaluation; and d) to avoid an hiatus between this project and a follow-on project several months will be needed to make an obligation with FY 90 money.

Assuming that the PACD will be extended by 6-9 months (to April - June 1990) and the project obligation will be in FY 90, the team suggests the following schedule:

May 1988. Amend current project agreement to extend PACD, revise the budget, and make other modifications.

May 1988. Prepare scope of work for population sector analysis and development of population/family planning strategy.

May 1988 - March 1989. Commission special studies and/or small pilot initiatives to aid in decision-making and strategy design.

September - October 1988. Conduct a sector analysis and develop a population/family planning strategy.

March 1989 - July 1989. Prepare and submit the Project Identification Document.

August 1989. Approve the Project Identification Document.

August 1989 - December 1989. Conduct special analyses (e.g., technical, administrative, institutional) for project design.

January 1990 - April 1990. Prepare Project Paper.

May 1990. Authorize Project Paper.

July 1990. Obligate funds.

ANNEX A

RECOMMENDATIONS

Management

- 1) MOH should keep MFEP informed about all public sector project activities through periodic reports and meetings. MFEP and MOH should meet to clarify what reporting requirements are necessary.
- 2) MFEP, MOH, DANAFCO and USAID should hold quarterly meetings to review the private and public sector components of the project.
- 3) MFEP and USAID should meet to review the overall PL 480 agreement and use of counterpart funds for all projects, with the objective of unblocking funds and streamlining procedures (as is currently being discussed by MFEP and Canada).
- 4) MFEP, MOH, and USAID should endorse and seek to implement the following recommendation included in the "Legon Plan of Action on Population" (1986 Ghana National Conference on Population and National Reconstruction):

"The National Family Planning Programme be restructured into a National Population Commission representing the interests of both the public and private sector organizations, and that a Population and Human Resources Secretariat be established within the Ministry of Finance and Economic Planning to service the National Population Commission. Such a secretariat will only be a coordinating agency, while other agencies in both the public and private sectors implement programmes on population."

- 5) MOH and USAID should independently and then together review the project's progress, taking a fresh look at project plans, budgets, achievements, and difficulties. They should examine how individual project activities might be better coordinated, and they should develop an overall implementation plan and revised budget for the project.
- 6) MOH should seek ways to further increase its responsibilities for planning, implementing, and managing the public sector component of the project, including coordination of various activities within the MOH.
- 7) MOH should more actively promote coordination among donors and the GOG in the health/family planning sector.
- 8) DANAFCO should demonstrate strong leadership and commitment to developing and managing the entire Contraceptive Social Marketing Program, paying particular attention to marketing and use of management information systems.
- 9) DANAFCO, with USAID support, should recruit an experienced technical adviser who, during periodic 2-3 month visits to Ghana, would increase the knowledge and skills of DANAFCO's CSMP personnel, especially the Coordinator and Marketing Manager, and would assist them with: a) basic marketing;

b) program development and coordination; c) use of management information systems; d) advertising and marketing research; and e) program planning, scheduling and reporting.

10) DANAFCO, with USAID assistance, should have its CSMP Coordinator and Marketing Manager: a) visit successful contraceptive social marketing programs elsewhere (such as the Nepal CRS Company Ltd. in Kathmandu); and b) attend appropriate courses on social marketing, project development and management, and community-based distribution (such as at the Center for Population and Community Development in Bangkok, Thailand).

11) DANAFCO should review present CSMP personnel assignments and management structure. It should develop a personnel plan including incentives for program achievements. DANAFCO should give the marketing manager appropriately increasing responsibility for CSMP management.

12) DANAFCO should review its existing CSMP marketing plan, update and modify it as needed, and use it as a regular tool.

13) DANAFCO should establish a CSMP Advisory Council of 15-20 members to meet at least semi-annually and provide a regular forum for guidance, coordination, and support for the Contraceptive Social Marketing Program. MOH should chair the meetings with DANAFCO acting as Secretary. Composition should include representatives from government and non-governmental organizations, professional associations, non-profit and commercial companies, and major family planning groups.

14) DANAFCO should modify its quarterly reports to include: depot-to-retailer sales, identification of all retail outlets, and data on retailers.

15) USAID should seek ways to further shift responsibility for implementing and managing the project from the Project Officer and CAs to Ghanaians in MOH and DANAFCO.

16) USAID and MFEP should meet to review the overall P.L. 480 agreement and use of counterpart funds for all projects, with the objective of unblocking funds and streamlining procedures.

17) USAID should start actively recruiting now for a qualified Population Officer to replace the incumbent, with at least two weeks of overlap before the incumbent's tour is completed.

18) USAID should immediately request AID/W to provide complete information to the Mission and WAAC on project expenditures for contraceptives and buy-ins to regional and central projects. With this information, the Mission and MOH should actively analyze and plan the entire project budget.

Technical Performance -- Public Sector Program

- 1) The project should provide continued technical assistance to MOH to improve the contraceptive supplies system. MOH should continue to provide training, supervision and monitoring to ensure refinement and sustainability of the contraceptive logistics supply and reporting system.
- 2) MOH and USAID should reprogram excess funds in the project's budget contraceptive line item in order to support other under-funded or needed project activities.
- 3) USAID should communicate to ST/POP the problems it is experiencing with the A.I.D. central contraceptive procurement system and request timely status reports and proper documentation for contraceptive shipments.
- 4) MOH should take immediate measures to get the current condom shipment out of the port and into the public health system. On a long-term basis, MOH should improve its overall drug management and logistics systems to avoid this kind of problem in the future.
- 5) In the context of all financial issues, MOH should communicate to and resolve with MFEP the problems resulting from the lack of funds for port charges and the implication of poor financial accountability for return-to-project funds. USAID should request that these issues be reviewed during the upcoming financial management assessment.
- 6) MOH should take an active role in coordinating with multilateral and bilateral donors to seek a long-term solution to the vehicle/transportation problem. It should also explore alternative mechanisms to improve distribution of supplies (e.g., piggy-backing distribution of contraceptives with EPI supplies, utilizing private sector vehicles).
- 7) MOH should take the necessary steps to insure that graduates from the Schools of Nursing and from the Auxillary Nursing Schools are capable of providing counselling and a limited range of family planning services (oral contraceptives, foaming tablets, condoms) upon graduation. To accomplish this the theory should be reinforced by skills development in a clinical and counselling practica.
- 8) A team of nursing tutors and service providers should conduct a facilities survey to identify potential training sites and modifications necessary for providing MCH/FP practica. MOH should review this survey with USAID to determine possible project assistance. MOH and USAID should also support the development, production and/or purchase of training materials and equipment for all technical schools and all in-service training sites.
- 9) MOH, with technical assistance from the project, should arrange an evaluation of all training participants in order to identify strengths and weaknesses in knowledge and skills, and to measure the impact of training. The evaluation should be planned at a time when training is in session so that observation of trainers may occur.

10) MOH trainers and coordinators should monitor and supervise all service providers including trainees on a regular basis. Factors which influence successful monitoring and supervision vary between regions and districts, thereby rendering one model for all regions inappropriate. MOH should convene quarterly district supervisors meetings to discuss alternative models and identify, in the process, factors which have facilitated performance with a view toward replication. A similar process should be conducted for Level B staff who have responsibility for supervising TBA's and community health workers.

11) MOH should consider lengthening the JHPIEGO-sponsored family planning clinical skills workshops to include 10 days for theoretical content and at least two weeks for skills development, including motivation of prospective clients. It should be understood by trainers and trainees that the completion of the practica is determined by competent performance of a specified number of procedures which may necessitate a longer practica.

12) MOH should request the project to send additional participants to the family planning clinical skills course at the University of Ibadan in order to support the further development of in-service training.

13) MOH should initiate coordination of all training at the central level. The project staff and national training coordinators should work with the deputy director of Nursing Education, all project training coordinators, and all individuals involved in training. This arrangement should attempt to develop or strengthen links among pre-service education and in-service training, as well as to enhance the quality of service delivery.

14) MOH should conduct a training needs assessment and develop a cohesive training plan.

15) The project should continue to provide technical and financial support to build MOH's IEC technical capability and to expand institutional development activities with a variety of other communication resources, such as GIMPA, UG/Legon, and the Ghana Broadcasting Corporation.

16) MOH should encourage and the project should provide support for the further development of a strategy to build high level commitment for family planning services within the context of maternal and child health.

17) USAID and PCS should work with WAAC to determine a solution to the problem regarding the different PACD dates for the PCS activities.

18) AVSC and JHPIEGO should continue to provide medical support to the MOH/VSC program to allow it to expand as demand warrants. They should also provide training in minilaparotomy with local anesthesia to private sector physicians who wish to offer such services if they have adequate facilities for doing so.

19) USAID and AVSC must continue to exercise vigilance in ensuring that all services provided are voluntary and that necessary documentation of this is adequately maintained.

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- 20) MOH and USAID should utilize the data from the DHS to the greatest extent possible to help shape the design of any follow-on project.
- 21) MOH and USAID should schedule the follow-on CPS as late as possible to allow for the most effective measure of project impact on contraceptive prevalence in Ghana.
- 22) MOH and USAID should insure that DHS data are made widely available to other GOG/donor projects and activities. DHS data could be especially useful for training and IEC purposes.

Technical Performance -- Private Sector Program

- 1) DANAFCO, MOH, MFEP, and USAID should confirm the target population for CSMP after considering the target populations of other Ghanaian organizations involved in family planning (including MOH, the Planned Parenthood Association of Ghana, and the Christian Council).
- 2) DANAFCO and MFEP should review the pricing structure for CSMP now and at least once each year as stipulated in the MFEP-DANAFCO contract.
- 3) An independent firm should assess financial aspects of CSMP, including the issue of self-financing, and it should submit recommendations on achieving self-financing.
- 4) DANAFCO should test prices of products prior to making national pricing decisions.
- 5) DANAFCO should devote greater efforts to developing, testing, and implementing message appeals in a well-coordinated campaign which will aggressively market the product.
- 6) DANAFCO should place notices in the press requesting that agencies, individuals and/or groups with consumer advertising and promotional experience send a summary of their education, training, and experience to DANAFCO. This may identify further candidate agencies or individuals for CSMP in the future.
- 7) To keep abreast of market changes, DANAFCO should conduct a regular monthly distribution check in at least Accra. It should visit 50 shops each month in a regular fashion, checking for inventory, competitive products, prices, and general comments from the shop salespeople. DANAFCO should also ask its salesmen to obtain simple market information when they are in the field.
- 8) DANAFCO should investigate new options for conducting market research. It should utilize the services of its research director to evaluate, select and develop market research personnel or groups for CSMP.

9) DANAFCO should immediately package all Norminest pills, including the instruction insert. When the package and insert are ready, DANAFCO should replace all discolored loose Norminest cards with the new package and return the discolored cards to headquarters for disposal. The remaining good loose cards should also be packaged.

10) DANAFCO should take advantage of the Kamal packaging change to improve the color and printing quality, and perhaps also the graphic image. DANAFCO should also investigate the packaging of condoms.

11) Prior to training more pharmacists and chemical sellers, DANAFCO should evaluate the course and proceed quickly with its plans to evaluate those who have already completed the training. The evaluation strategy should include: selection of an appropriate sample of trainees; giving the selected trainees a questionnaire to test their knowledge of contraceptives technology; and employing mystery shoppers who would be directed to purchase contraceptives and report on retailers' client screening and instructions for contraceptives use.

12) Following evaluation of the course and trainees, DANAFCO should modify the course if necessary and establish and implement procedures to monitor trainees.

13) DANAFCO should devise and implement a plan for educating other staff in the shops of trained pharmacists and chemical sellers.

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ANNEX B

SCOPE OF WORK FOR MID-TERM PROJECT EVALUATION | OF GHANA CONTRACEPTIVE SUPPLIES PROJECT (PROJECT NO. 641-0109)

BACKGROUND

On August 8, 1985, the Assistant Administrator for Africa authorized the four-year Ghana Contraceptives Supplies Project (641-0109) for a total life-of-project amount of \$7.0 million. The Mission signed a grant agreement for the project with the Government of Ghana (GOG) on September 19, 1985. The project activity completion date is September 18, 1989.

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

Over the life of the project, the public sector MOH component seeks to:

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

The MOH is responsible for organizing, coordinating and implementing all public sector family planning activities. For specific tasks the MOH has received technical assistance from regionally or centrally funded agencies, including Johns Hopkins Population Communication Services (PCS), American College of Nurse-Midwives (ACNM), Centers for Disease Control (CDC), Johns Hopkins Program for International Education in Gynaecology and Obstetrics (JHPIEGO), Association for Voluntary Surgical Contraception (AVSC), and the Columbia University Center for Population and Family Health.

The private sector CSM component of the project seeks to:

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

In March, 1986, the Government entered into a host country contract with DANAFCO Limited to organize and implement the private sector CSM Program. During the first year, for specific marketing and advertising tasks, DANAFCO subcontracted with LINTAS/Ghana Limited. For retailer training, DANAFCO subcontracted with PHARMAHEALTH Limited. SOMARC, a centrally funded organization, has provided technical and some financial support for marketing research, advertising, training and commodity packaging.

The Mission has actively utilized central or regionally funded projects which complement the Ghana Contraceptive Supplies Project in developing its overall population program strategy. Included in the broad Mission effort are activities such as natural family planning, supported by International Federation of Family Life Education; training and family planning service delivery by private sector midwives in conjunction with the American College of Nurse Midwives; surgical contraception organized by the Association for Voluntary Surgical Contraception; operations research, conducted by Columbia University; biomedical and social research conducted with Family Health International; family planning curricular development and physician and nurse training in laparoscopy and reproductive health, assisted by JHPIEGO; demographic data collection, organized and assisted by Westinghouse/Demographic-Health Surveys; family planning IEC, supported by Population Communications Services; and population policy development, in conjunction with the Population Reference Bureau/IMPACT and RAPID II projects.

In concert, all of these activities aid in the achievement of the overall purpose of the bilateral project of increasing voluntary use of safe, effective and appropriate contraceptives by the Ghanaian population.

OBJECTIVE OF THE MID-TERM EVALUATION

The primary objective of the mid-term project evaluation will be to constructively review the management and technical aspects of both the public and private sector components of the project and to make recommendations to facilitate ultimate achievement of the overall project purpose. The evaluation will assess the administrative and programmatic aspects of the project in terms of overall organization, appropriateness, effectiveness and efficiency. The expected outcome of the evaluation is a detailed report which specifies project strengths and weaknesses, identifies any problem areas, and recommends specific actions necessary to strengthen or improve the planning, execution, and monitoring of the project components. The project evaluation report also is expected to identify future project directions, as well as outline potential structures and activities for a follow-on project.

While the evaluation team will review project accomplishments to date, the primary focus will be on whether the necessary management and programmatic systems are in place to reach the expected project outputs by the project completion date. In other words, this evaluation is intended to be a "process" evaluation rather than an "impact" evaluation and is expected to offer constructive criticism for overall project improvement.

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FIELD EVALUATION DATES

Three weeks, February 23 - March 11, 1988.

STATEMENT OF WORK

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

1. Have any social, political or economic changes occurred in Ghana since development of the project design which might impact on the successful completion of the project?
2. Are the assumptions on which the project design was based still considered valid?
3. Is the overall project design considered both valid and appropriate in the current context?
4. How effective and appropriate are the following aspects of both the MOH and CSM program components:
 - management capability, including program planning and administration, budget and financial management, personnel development, management and supervision, service site management;
 - training of personnel, supervision and oversight of participating institutions, and development and maintenance of relevant standards of services;
 - information, education and communications (IEC) strategies in terms of their cultural sensitivities, appropriateness, effectiveness, and potential impact.
 - commodity procurement, storage, distribution and resupply systems;
 - compilation and utilization of service statistics; and
 - extent and quality of service delivery.
5. Has satisfactory progress been made towards achieving project outputs in both public and private sector components?
6. Have the training activities of the public sector component been conducted according to plan in a timely manner and are they achieving their stated purpose?
7. How effective is the project's organizational structure with respect to overall project management and coordination, as well as its capability to provide technical and financial inputs in a timely manner?
8. What are the prospects for both the financial and institutional sustainability of project activities after the completion of USAID assistance?
9. In what manner and how effectively have centrally-funded and regionally funded projects been utilized to augment, supplement or complement project activities?
10. What is USAID's current role in managing and providing oversight to the project?

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Upon completion of their assessment the evaluation team will (1) make specific recommendations for improvements in the project which will enhance the prospects for success and (2) make a recommendation as to the feasibility of a follow-on project, and, if feasible, recommend possible future activities.

The official references for this evaluation are the signed project agreement, subsequent amendments, project implementation letters and approved financial reports. Useful references are the project paper and its appendices, project authorization, project correspondence, PIO/T/C/P's, project implementation reports, consultant reports, trip reports, centrally-funded project agreements and contracts, research findings, health sector assessment and financial assessment reports. These documents will be made available to team members at the time of the evaluation.

EVALUATION TEAM COMPOSITION

The evaluation will be a joint effort between USAID and the GOG. There will be a team of international and Ghanaian experts.

The external evaluation team will be composed of a management/evaluation specialist, who will serve as the team leader, a contraceptive social marketing specialist, a family planning program specialist, and a training specialist. Each team member will work with an identified Ghanaian counterpart who has extensive knowledge and background with regard to their specific project component. The Ghanaian members will be identified by the GOG with concurrence by USAID, and will serve as in-country resource persons and points of contact for external evaluation team members.

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

1. Management/Evaluation Specialist. Expert with previous experience in developing large-scale population/family planning projects/programs; knowledge of and experience in AID management, particularly at the Mission level; graduate level training in administration, management, or social science with field research experience; working experience in LDCs, preferably Africa. Experience in conducting AID Evaluations and managing population projects is desired. (Expected to be AID/W or REDSO/WCA Project Development Officer).
2. Family Planning Program Specialist. Expert in broad range of family planning program elements (information, education, and communication (IEC), training, service standards, and contraceptive supply management). Experience with family planning program implementation in the African setting; graduate level degree in population, health or health-related field. Experience in dealing with centrally and regionally funded population projects and Cooperating Agencies. (Expected to be REDSO/WCA Population Officer).

3. Contraceptive Social Marketing Specialist. Expert with state-of-the-art knowledge of social marketing program concepts and program options; extensive field experience in social marketing, particularly commercial retail sales of contraceptives; knowledge of advertising and marketing of contraceptives in African milieu; experience in training, supervision, and management of retail pharmacists, chemical sellers, and/or vendor-type sellers. Graduate level training in behavioral science. (Expected to be IQC Contractor).
4. Training Specialist. Expert in training, particularly in the family planning field. Knowledge of and experience with training needs assessments, curriculum, training program and training materials development, and training evaluation. Extensive experience in developing, managing and evaluating family planning training programs. Graduate level training in adult education, communications or equivalent. (Expected to be an AID/W Direct Hire).

EVALUATION METHODOLOGY

1. Preparation

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

In addition, two advance reports will be prepared: a) a review of the contraceptive supply and logistics system, progress and problems, to be conducted by a technical consultant from the Centers for Disease Control; and b) a financial management review of the overall financial systems to be conducted by a financial specialist contracted under a REDSO Indefinite Quantity Contract. These reports will be prepared in January and submitted to the evaluation team by the beginning of the field work. Each of the key centrally-funded agencies (PCS, SOMARC, etc.) will be asked to submit to USAID a brief summary of major activities and accomplishments prior to the evaluation. These reports are expected to provide baseline information on the key support systems for the overall project.

2. Field Evaluation

The field evaluation will include three phases: orientation; fact-finding; data analysis and development of recommendations. Upon arrival of evaluation team USAID project officer will discuss with the team the purpose and objectives of the evaluation to ensure mutual understanding. Also, team will be briefed on project, its progress and status, host country participation in the evaluation, logistical arrangements, etc.

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- Orientation. For the initial few days of the in-country evaluation, the project evaluation team and designated Ghanaian counterparts will meet to refine the terms of reference; delineate responsibilities among the team members; review scopes of work; read project documents; develop evaluation tools, if necessary; hold meeting with USAID leadership on evaluation expectations; conduct team building exercises.
- Fact-finding. For approximately one and one half weeks the team will separate into work groups; make the appropriate field visits; conduct interviews with government and private sector project participants; observe project activities and work, etc.
- Analysis and development of recommendations. During the last week, the evaluation team members will prepare a written summary of their respective observations and conclusions. The evaluators will hold meetings to reach a consensus of recommendations and prepare the comprehensive evaluation report.

3. Evaluation Implementation Schedule

<u>Action</u>	<u>Target Completion Date</u>	<u>Person Responsible</u>
Select Evaluation Team Members	31 December 1987	Project Officer
Draft PIO/T for Project funded team member	15 January 1988	Project Officer
Collect and organize pertinent documents and information for evaluation team	22 January 1988	Project Officer
Review plans for Evaluation Team Planning Meeting/develop preliminary itinerary and schedule appointments	31 January 1988	Project Officer
Brief Evaluation Team and discuss purpose and objectives/introduce to host country participants	29 February 1988	Project Officer
Evaluation Team Planning Meeting	23-24 February 1988	Team Leader
Review pertinent documents, develop evaluation tools, meet with project officer if necessary	24-25 February 1988	Team Leader
Fact-finding by Team Members	26 February - 6 March 1987	Team members follow individual assignments under supervision of Team Leader

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Analysis and Report Preparation	7-10 March 1987	Team members under guidance of Team Leader
Formal Briefing to USAID and GOG/draft report delivered	11 March 1987	Team Leader
Final Report Submitted to USAID/Ghana	11 April 1987	REDSO/WCA team members

Reporting Requirements

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

A draft evaluation report will be submitted to USAID/Ghana prior to the departure of the Team Leader. REDSO/WCA will be responsible for preparation of the final report. The report will be submitted to USAID within 30 days of the completion of the in-country evaluation work. Evaluation observations, findings and recommendations will be reviewed by USAID and the GOG and a plan of action will be developed by the Mission to implement accepted recommendations.

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

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

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

Funding

Management/Evaluation Specialist will be provided either by Redso/WCA or funded with Mission OE funding. If the latter is required the cost is estimated to be approximately \$5,000. The Family Planning Program Specialist will be provided by Redso/WCA at no cost to the Mission. The Training Specialist will be obtained from the Office of Population, Information and Training Division, utilizing Mission OE funding of approximately \$5000. The Contraceptive Social Marketing Specialist will be obtained through an IQC firm utilizing project funding at a cost of approximately \$15,000. Transportation, secretarial services and other logistics requirements in Ghana will be provided by the Mission.

* See A.I.D. Evaluation Handbook, April, 1987.

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ANNEX C
A.I.D. REGIONAL AND CENTRAL PROJECT INPUTS

AGENCY	ACTIVITY	FUNDING
(1) American College of Nurse Midwives (ACNM)	Three year project with Ghana Registered Midwives Association to train 100-150 private midwives to add family planning to their practices.	\$525,000 (Family Health Initiatives II)
(2) Association for Voluntary Surgical Contraception (AVSC)	Established two VSC centers in Ghana and rehabilitated two operating theaters. Trained two VSC physician/nurse counselor teams. Program being expanded throughout Ghana.	(a) \$70,000 (in-country costs to date) (b) \$25,000 projected future in-country and third country training costs.
(3) Centers for Disease Control/ John Snow Inc. (Family Planning Logistics Management Project)	Assessment of MOH contraceptives logistics system, preparation of plan of action for improvement program, training and materials development assistance.	(a) \$35,000 for technical assistance to date (b) \$35,000 for future technical assistance.
(4) Columbia University (Operations Research Project)	(a) Operations research project with Traditional Birth Attendants (TBAs) to determine how best they can be trained to deliver services in rural villages. (b) Operations research project with Ghana Registered Midwives Association to ascertain how effective it is for private midwives to deliver family planning services through their maternity homes. (c) Technical assistance and assessment of potential for Ghanaian market women to sell contraceptives in the market place (project planned).	(a) \$57,000 (excludes technical assistance). (b) \$43,137 (excludes technical assistance). (c) \$20,000 (bilateral project funds for project through Buy-in).

AGENCY	ACTIVITY	FUNDING
(5) Westinghouse/Demographic Health Surveys	Nationwide demographic health survey carried out with Ghana Statistical Service. Sample of 4,500 female respondents. Project includes extensive technical assistance and computers.	(a) \$126,000 (Westinghouse) (b) \$ 31,000 (UNFPA) (c) \$ 36,000 Local counterpart funds (under bilateral Contraceptive Supplies Project) (d) 8 UNICEF and 1 UNFPA vehicle on loan
(6) Enterprise Program	Assessment of Employee Health Schemes. Proposal preparation for project with private sector midwives. Business management training for private sector midwives.	(a) \$30,000 for technical assistance. (est.) (b) \$44,000 for training
(7) Family Health International (FHI)	Research projects on: (a) Progesterone Only study in breast feeding women. (b) Norplant implant system acceptability survey. (c) Acceptability of spermicidally lubricated condoms.	(a) \$11,820 (b) \$32,200 (c) \$ 2,500
(8) Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO)	(a) Project with MOH to establish family planning clinical training centers for public sector nurse midwives, to revise pre-service nurse and midwife school curricula adding sufficient family planning. (b) Training for nine physician and nurse teams in laparoscopy and establishment of a laparoscopy maintenance center in Accra. (c) Reproductive health training in U.S. and third countries for 56 physicians, nurses and midwives, MOH.	(a) \$62,000 (b) \$45,000 (est.) (c) \$150,000 (est.)

AGENCY	ACTIVITY	FUNDING
(9) Johns Hopkins University/ Population Communications Services (JHU/PCS)	Assessment of IEC area in Ghana and development of three year family planning IEC strategy. Project with MOH/HED to carry out a three year strategy to produce materials for both public and private sectors, use media reach, train public and private sector health providers.	(a) \$475,000 (Family Health Initiatives II) (b) \$357,000 (bilateral CSP) (c) \$ 90,000 (PCS central funds)
(10) Family Planning International Assistance (FPIA)	(a) Three sub-projects, one in IEC and service delivery, one in service delivery and a survey for private midwives. (b) Contraceptives for various private clinics, private midwives, MOH.	(a) \$46,000 (b) \$100,000
(11) Management Sciences for Health (a) PRITECH	Five man-months of technical assistance for conducting comprehensive assessment of MOH logistics system and preparation of a plan of action for logistics improvement and technical assistance to develop communications plan for oral rehydration therapy promotion campaign.	(a) \$100,000 (est.)
(b) Family Planning Management Training Project	Technical assistance for developing MOH training manual and MOH master training plan.	(b) \$40,000 (est.)
(12) Program for Appropriate Technologies in Health (PATH)	Established a local production facility for ORS production and provided technical assistance for development of an ORT strategy. ORS will be distributed through the contraceptive social marketing network.	(a) \$110,000 (loan for equipment) (b) \$ 30,000 (promotion) (c) \$250,000 (technical assistance) (est.)

AGENCY	ACTIVITY	FUNDING
(13) Population Reference Bureau (PRB) IMPACT Project with assistance from Futures Group/RAPID II Project.	Project with University of Ghana, Legon to develop overt support for population/family planning program. Consists of presentations, issue booklets, seminars and media publications and broadcast.	(a) \$122,000 (in country) (b) \$ 60,000 (technical assistance) (est.)
(14) Social Marketing for Change/ Futures Group (SOMARC)	Assistance to contraceptive social program in research (marketing), advertisement development, management information systems, training of retailers.	\$500,000 (est.)

A.I.D. REGIONAL AND CENTRAL PROJECT INPUTS

	PUBLIC SECTOR						PRIVATE SECTOR					
	Service Delivery	IEC	Training	Research	T/A	Logistics/ MIS	Service Delivery	IEC	Training	Research	T/A	Logistics/ MIS
ACNM							X	X	X		X	
AVSC	X	X	X		X			X				
CDC/JSI			X		X	X					X	X
Columbia University			X	X	X				X		X	
Westinghouse/DHS				X	X				X			
Enterprise Program					X				X		X	
FHI			X	X								
FPIA							X	X	X	X		
JHPIEGO	X	X	X		X			X				
JHU/PCS		X	X	X	X			X	X		X	
MSH		X	X		X	X		X			X	
PATH							X	X			X	
PRB/IMPACT		X			X			X				
FUTURES GROUP/SOMARC							X	X	X	X	X	X

ANNEX D

PERSONS CONTACTED

Ministry of Health

Dr. Moses Adibo	Director of Medical Service
Dr. Joseph Adamafio	Deputy Director of Medical Services (Public Health)
Dr. Joseph Otoo	Deputy Director of Medical Services (Manpower and Training)
Dr. Charlotte Gardiner	Medical Officer in Charge of Maternal-Child Health/Family Planning
Ms. Victoria Assan	Principal Nursing Officer
Mrs. Martha Osei	Director of Health Education Division
Mrs. Mary Kotei	Deputy Director of Health Education Division
Ms. Stella Ahenkora	Kumasi Maternal and Children's Clinic, Public Health Nurse Midwife
Mrs. Miriam Hornsby-Odoi	Director of Nursing Services
Mrs. Joana Samarasinghe	Deputy Director, Nursing Education
Mrs. Florence Quarcoopome	National Training Coordinator
Mrs. Mary Osaë-Addae	National Training Coordinator
Mr. Gladys Kankam	Senior Tutor, School of Midwifery
Mr. Florence Ashithey	Senior Nursing Officer, FP Consultant, Korle Bu FP Clinic
Mrs. Grace Adubah	Nurse Midwife, Korle Bu FP Clinic
Mrs. A. Offei	Nurse Midwife, Korle Bu FP Clinic
Miss Millicent Graham)
Miss Gloria Djan) State-registered nursing students
Mr. Rex Kudjae)
Miss Ayesha Boateng) (on rotation in FP Clinic)
Miss Phyllis Bosque-Hamilton)	
Dr. Sam Adjei	Epidemiologist, Greater Accra Region
Miss Victoria Quarshie	Principal, School of Nursing, Korle Bu Hospital
Mrs. Grace Addo	Tutor, Korle Bu Hospital
Mrs. Caroline Tetteh	Tutor, Korle Bu Hospital
Mrs. Dorothy Lomo-Tettey	Tutor, Korle Bu Hospital
Mrs. Emily Amanor-Boadu	Private Midwife
Mrs. Virginia Tamakloe	Principal Nursing Officer, MCH/FP, Accra Region
Mr. William Sackeyfio	Graphic Artist

Ministry of Finance and Economic Planning

Ms. Eleanor Quist	Principal Secretary, International Economic Relations Division
Mr. Michael Baddoo	Desk Officer for the Americas, International Economic Relations Division

DANAFCO

Mr. A. Yaw Berko
Mr. L.S. Nsiah Akuetteh
Mr. Kwaku Amponsah
Mr. J.Y. Owusu
Mr. Francis Frimpong
Mr. Joseph Kwadwo Boadu

Managing Director
Program Coordinator, CSMP
Marketing Manager, CSMP
Research Coordinator, CSMP
Regional Pharmacist
Bookkeeper

USAID

Mr. Gary Towery
Mr. Frank Pavich
Dr. Ray Kirkland
Mr. Joanna Y. Laryea
Mr. Robert K. Addai

A.I.D. Representative
General Development Officer
Population Officer
Assistant Population Officer
Chief Accountant

U.S. Embassy

Mr. Lee Graham

Economic/Commercial Officer

World Bank

Mr. Nicholas Bennett
Dr. Fred T. Sai

Education and Health Planner
Senior Advisor, Population and Human
Resources Department

PharmaHealth Centre Ltd.

Mr. James Pearce-Biney
Mr. Mohammed

Managing Director
Lecturer/Training

Planned Parenthood
Association of Ghana (PPAG)

Mr. Ernest Kwansa
(Chief) Nana Asumadu Sakyi

Executive Director
Regional Coordinator, Ashanti Regional
Branch

Mrs. Stella Enninful-Eghan

Family Planning Nursing Officer, Ashanti
Regional Branch

Lintas Ghana, Ltd.

Mr. Jacob Obetsebi-Lamptey
Mr. Kwasi Bruce
Ms. Norkor Duah
Ms. Sally Hammond
Mr. Kwaku Mensah-Bonsu

Managing Director
Research Director
Account Executive
Client Services
Client Services

The Futures Group/SOMARC

Mr. Steve Hawkins

PRITECH/Academy for Educational Development

Mr. Peter Spain

Population Communication Services

Mr. Maxwell Senior

Senior Program Officer

Ms. Wilma Lynn

Program Officer

Westinghouse Demographic and Health Survey

Mr. Trevor Croft

University of Ghana

Dr. Michael K. Mensah

Department of Geology

E.N. Omaboe Associates, Ltd.

(Chief) E.N. Omaboe