

**FINAL EVALUATION OF THE  
GHANA FAMILY PLANNING AND HEALTH  
PROJECT (FPHP)  
(641-0118)**

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## ABBREVIATIONS

ACNM	American College of Nurse Midwives
AIDS	Acquired Immunodeficiency Syndrome
AIDSCOM	AIDS Communication Project
AIDSTECH	AIDS Technical Assistance Project
AVSC	AVSC International (formerly Association of Voluntary and Surgical Contraception)
CA	Cooperating Agency
CBD	Community-Based Distribution/Distributor
CBS	Consumer Baseline Survey
CCP	Center for Communication Programs (Johns Hopkins University)
CME	Consultant Management Enterprise
CP	Condition Precedent
CPR	Contraceptive Prevalence Rate
CPSG	Contraceptive Pricing Sustainability in Ghana
CSP	Contraceptive Supply Project
CYP	Couple Year of Protection
DHS	Demographic and Health Survey
EDL	Essential Drug List
EOPS	End of Project Status
EU	European Union
FHI	Family Health International
FP	Family Planning
FPHP	Family Planning and Health Project
FPLM	Family Planning Logistics Management Project
Futures	The Futures Group International
GAF	Ghana Armed Forces
GBC	Ghana Broadcasting Corporation
GDHS	Ghana Demographic and Health Survey
GHANAPA	Ghana Population and AIDS Project
GNFPP	Ghana National Family Planning Program
GOG	Government of Ghana
GRMA	Ghana Registered Midwives Association
GSMF	Ghana Social Marketing Foundation
GSMP	Ghana Social Marketing Program
GSS	Ghana Statistical Service
GTZ	Association for Technical Cooperation (Germany)
HEU	Health Education Unit
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HPN	Health, Population, and Nutrition Office
ICPD	International Conference on Population and Development
IEC	Information, Education, and Communication
IERD	International Economic Relations Division, MFEP
INTRAH	International Training in Health Project
ISTI	International Science and Technology Institute
IUD	Intrauterine Device

JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
KABP	Knowledge, Attitudes, Behavior, and Practice Survey
KATH	Komfo Anokye Teaching Hospital (Kumasi)
MCH	Maternal and Child Health
MFEP	Ministry of Finance and Economic Planning
MIS	Management Information System
MOE	Ministry of Education
MOH	Ministry of Health
MSRI	Marketing Survey and Research Institute
NACP	National AIDS Control Program
NGO	Nongovernmental Organization
NPA	Non-Project Assistance
NPC	National Population Council
NPHRC	National Population and Human Resources Council
NTBA	National Traditional Birth Attendants
OC	Oral Contraceptive
ODA	Overseas Development Administration (UK)
OPTIONS	Options for Population Policy Project
ORS	Oral Rehydration Salts
PACC	Population and AIDS Coordinating Committee
PHC	Primary Health Care
PHRL	Public Health Reference Laboratory
POS	Point of Sale
PPAG	Planned Parenthood Association of Ghana
PPME	Program Planning, Monitoring and Evaluation
PSC	Public Services Commission
REDSO	Regional Economic and Development Services Office
RFP	Request for Proposal
RHEO	Regional Health Education Officer
RHMT	Regional Health Management Team
SA	Situation Analysis
SDP	Service Delivery Point
SSPU	Social Sector Policy Unit
STD	Sexually Transmitted Disease
T1 (2,3)	Tranche 1 (2, 3)
TA	Technical Assistance
TAC	Technical Advisory Committee
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VFT	Vaginal Foaming Tablets
VSC	Voluntary Surgical Contraception
WHO	World Health Organization

## EXECUTIVE SUMMARY

The Ghana Family Planning and Health Program is a six-year bilateral agreement consisting of three components: non-project assistance (US\$13 million); the Family Planning and Health Project (US\$15 million); and contraceptive procurement (US\$6 million) through the Contraceptive Procurement Project. The purpose of the total program is to lower fertility through maternal and child health (MCH) interventions and reduce the spread of HIV/AIDS. The project completion date is March 31, 1996.

The non-project assistance (NPA) component consists of economic assistance to support the government of Ghana's (GOG's) efforts to increase the demand for and use of modern methods of family planning (FP) by expanding the capacity of the public and private sectors to provide services, supplies, and information. Project components include demand generation through education, training, and advertising; delivery of contraceptives and other health services and products with emphasis on social marketing of contraceptives; improved logistics systems; support to the clinical laboratory system; and monitoring through management information systems and HIV serosurveillance.

The Family Planning and Health Program (FPHP) is administered by the Ministry of Finance and Economic Planning (MFEP), with responsibilities for program activities mainly delegated to the Ministry of Health (MOH). The FPHP project was implemented through an institutional contract with The Futures Group International (Futures) and its subcontractors, and a cooperative agreement with the American College of Nurse Midwives (ACNM); buy-ins to centrally-funded projects; and project support. Other projects carried out activities using central USAID funds.

The goal of achieving a drop in the total fertility rate from 6.4 in 1988 to 6.1 by 1995 has been met and exceeded. Analysis of data from the 1993 Consumer Baseline Survey (CBS), the 1993 Ghana Demographic and Health Survey (GDHS), and service statistics indicates that the increased level of contraceptive prevalence sought (that is 15 percent modern methods), should be nearly achieved by the end of the project, if the current pattern of contraceptive uptake continues.

### **Population and Family Planning Policy Environment**

Non-project assistance appears to have been an appropriate mechanism to spur reform, both at the level of national population policy and at the level of operational reforms affecting the availability and accessibility of family planning services. All Conditions Precedent (CPs) linked with policy change and set as terms for tranche releases were met, albeit with delays.

Important accomplishments include the establishment of the National Population Council (NPC) by legal instrument, Law 485 of 1994; the preparation of a comprehensive set of action plans for policy implementation; and the reclassification of contraceptive products to be legally offered by a wider array of distributors.

## **National Population Council Secretariat: Managing the Policy Agenda, Coordinating the Population Program**

The NPC Secretariat's capacity to manage the population and family planning agenda is not yet assured. Senior staff members have not been appointed; a decision has not yet been made in the president's office as to who will represent the NPC in Cabinet meetings; and the Secretariat is not yet installed in its office facilities.

The Secretariat was able to successfully harness the energies of five multisectoral teams in the preparation of the "Action Plans for the Revised National Population Policy," completed in 1994. The process contributed to a better understanding of population as an integral component of development planning that spans sectoral interests. It also helped to formalize among the participants relationships that had previously been informal and *ad hoc*.

### **Demand Creation for Family Planning Services**

Information and education activities of FPHP address knowledge constraints identified in the GDHS and the CBS. An outstanding effort to develop a coordinated public-private sector family planning and HIV/AIDS information campaign was orchestrated by the Health Education Unit (HEU) of the MOH. The strategy included mass media and interpersonal components at both the national and regional levels. Plans called for the public sector to focus on broad public health, family health, family economic issues, and HIV/AIDS, including generic information about various methods. The private sector (Ghana Social Marketing Foundation, GSMF) was to produce brand advertising and promotional materials primarily for commercial marketing.

Lack of NPA funds seriously hindered the regional campaigns and did not allow the participation of the public sector in the coordinated mass media campaigns as planned. Nonetheless, a substantial improvement was made in the institutional capability of HEU.

Technically good advertising materials were prepared by GSMF, but it encountered problems in airing some television commercials. Leadership audience testing may have been flawed, or efforts to gain support and understanding from potential dissenting groups were not made strongly enough. A negative reaction came from a vocal minority who interpreted the ads as encouraging promiscuity. Part of the problem stemmed from the lack of legitimizing mass media support from the public sector.

### **Capacity Building, Training, and Counseling**

Once people are informed of the benefits and availability of family planning, they require individual counseling to select appropriate methods. More than 7,100 private and public sector trainers, communicators, and service providers were trained through FPHP programs, improving their interpersonal counseling skills.

## **Service Delivery**

Service delivery is offered through two channels--MOH MCH/FP activities and commercial distribution activities of the GSMF. Smaller activities with traditional birth attendants, private midwives, nongovernmental organizations (NGOs), and business enterprises are also included in the service network.

NPA funding has assisted the MOH to substantially increase family planning coverage. Training has been supported; regular supervisory and evaluative meetings have been held with regional officers; management information gives attention to family planning and supervision; and outreach has been facilitated.

The MOH is undertaking many of the efforts necessary to place priority emphasis on family planning in an MCH/primary health care (PHC) program through its policy statements, service delivery guidelines, and personnel practices. Indications are that family planning is becoming a part of all the relevant activities of the health center. Additionally, the mutually supportive approach with which FP and HIV/AIDS are addressed is a positive influence on the development of both program areas.

The provision of an adequate supply of contraceptives and technical assistance in improving their ordering, storage, and distribution has substantially improved consistent availability.

## **Support to Contraceptive Social Marketing**

The social marketing project component underwent basic organizational change under FPHP. Rather than continuing program planning, monitoring, promotion, and sales with a sole distributor of pharmaceutical products, a new management unit was developed. Its strategy calls for a lean management style and utilization of contracts with other agencies for the bulk of implementation and distribution activities. Currently carried out by three companies, this approach is no doubt less costly than a strategy involving the development of in-house advertising, promotion, research, logistics, and sales capability.

In the long run this approach may be more sustainable as it does not need to completely stand alone. However, sustainability also requires generating a substantial market in a relatively short time frame. With the approach chosen, GSMF is burdened by the inertia of external established business practices. This may not permit as aggressive or innovative an approach as would a more in-house implementation. This approach depends on such a limited staff that any staff turnover could substantially disrupt program operations.

Analysis of couple years of protection (CYPs) achieved by sector shows a dramatic growth in contraception during the project period, with the greatest increase attributable to the MOH. FPHP expected to see a similar increase in the GSMF, which instead has remained relatively constant, probably due to its emphasis on short-term methods and their resulting lower CYPs.

## **HIV/AIDS Prevention and Control**

Under FPHP, the National AIDS Control Program has made important gains. HIV/AIDS activities are being integrated into the core programs of the MOH at both central and regional levels. Important steps were made to involve other sectors in the fight against AIDS and create broad-based support for HIV/AIDS prevention and control. There are indications of significant improvement in specific knowledge about HIV/AIDS and condom use. In addition, FPHP has established the foundation for rehabilitation of the Ghana laboratory network and made significant progress in improving the technical skills and quality of laboratory staff.

It is likely that FPHP will meet the project objectives to improve knowledge of HIV/AIDS and safe sex behaviors, but this can only be determined once additional survey data are collected.

## **Information, Education, and Communication**

The MOH, with the technical assistance of The Futures Group, managed to successfully integrate the information, education, and communication (IEC) activities related to HIV/AIDS prevention into the core programs of the MOH, the social marketing program, and 18 NGOs. In addition, the Ministries of Information, Education, Mobilization, and Social Welfare and the Ghana Armed Forces were involved in ongoing targeted IEC initiatives.

## **Laboratories and Health Information System**

Although the building and equipping of three out of the four zonal laboratories in Kumasi and Tamale and the regional laboratory in Sekondi/Takoradi are not yet completed, this component shows signs of success. The building of the Accra branch of the Public Health Research Laboratory (PHRL) has been completed, fully equipped, staffed, and outfitted with personnel trained for HIV testing and other public health services. It is anticipated that all the remaining laboratories will be built, equipped, and functioning by the end of the FPHP.

One computer was supplied to the Center for Health Information. Discussions were initiated with the new head of the HEU, who is taking important new steps to strengthen the MOH's health information system (HIS) within the next five years in collaboration with the World Bank.

## **Program Management**

The GOG manages FPHP through a Technical Advisory Committee (TAC) chaired by the Ministry of Finance and Economic Planning and including representatives from implementing agencies and USAID. Additional management tasks are administered by the institutional contractor for the project portion of FPHP, the MOH for the NPA funds released to it, and the USAID/Health, Population, and Nutrition Office (HPN) for buy-ins, grants to Cooperating Agencies (CAs), and purchase orders.

Delayed release of NPA tranche funds impeded timely implementation of FPHP. Recent release of the third tranche—which generated nearly half of the local currency funds generated by the

combined tranches—provides the TAC with an opportunity to review FPHP objectives and fund remaining activities, particularly IEC and PHRL activities.

USAID/HPN has managed FPHP with increasing emphasis on the involvement of contractors, CAs, the GOG, and MOH. Funds for buy-ins and cooperative agreements have been expended in a timely fashion. Early project implementation was delayed by the belated addition of an HIV/AIDS component, development of the Request for Proposal (RFP) and awarding of the institutional contract.

The project portion of FPHP has managed its Scope of Work with particular attention to skills transfer and sustainability. GSMF, IEC, and PHRL activities succeeded in institutionalizing improved capacity. The managerial shift from a single packager/distributor under the Ghana Social Marketing Program (GSMP) to multiple distributors under GSMF has increased market penetration. It has also inflated the quantity of contraceptives at central level warehouses. Nearly expired condoms are in circulation and are found at central warehouses. These condoms must be withdrawn from circulation.

### **Over-Arching Developments**

Increasingly, respondents within MOH and MFEP claim ownership of the MCH/FP program and, to a lesser extent, the HIV/AIDS program. There is a growing sense of the need to develop a comprehensive family planning and health care program.

Observers both within and outside the MOH cited the strengthened management capacity that has developed in large measure due to the requirements of FPHP. Staff skills in work planning and budgeting are stronger, and staff confidence has grown; this is evident at headquarters as well as at the regional level.

Quality assurance has emerged as a topic of concern to service providers and policy-makers alike. While there is still far to go in the achievement of uniformly high-quality services through the Ghana health system, increasing attention is being paid to questions of infection control, provider bias, and inappropriate application of client precautions.

Ghana's FP program blends social marketing, static clinic facilities, and outreach activities. The balance achieved among these delivery modes has implications for the method mix of the program. To the extent that services are extended to the rural population, the program will continue to address demand for short-term methods that are easily distributed at the community level, while also providing long-term methods for appropriate clients.



## SUMMARY OF RECOMMENDATIONS

1. USAID should review with the NPC Secretariat and the MOH the proposed structure of the NPC to determine if it is the best option to ensure successful implementation of the Secretariat role. (p. 11)
2. Major action is needed to staff the NPC Secretariat. Its legislative instrument should be reviewed and a determination made whether core staff must be appointed by the president. USAID should consider preparation and submission of a joint request for resolution to the president's office from donors and multilateral organizations involved in population, MCH/FP, and HIV/AIDS activities, although this raises the risk of an inappropriate appointee being installed. (p. 11)
3. The NPC Secretariat should identify a set of key indicators of the policy environment and program implementation and adopt them as measures of program status. The indicators suggested in the *Handbook of Indicators for Family Planning Program Evaluation* and illustrative evidence of their status in Ghana are presented in Appendix 4. Once indicators are identified, NPC should routinely monitor progress achieved. Updates on Indicator status should be included in the annual report and the proposed newsletter. (p. 12)
4. The NPC Secretariat should coordinate preparation of a technical agenda of issues of key importance to population, MCH/FP, and HIV/AIDS in Ghana and technical issues included in the PACC meetings. The findings of this evaluation should be included on the agenda of an upcoming PACC meeting. (p. 12)
5. The MOH and USAID should ensure that adequate funds generated by NPA disbursements are used to carry out substantial portions of the public sector IEC campaigns before project completion. Emphasis should be placed on mass media (radio and television), both to partially fill the gap of limited GSMF advertising and to legitimize the airing of increasingly specific messages about family planning and contraceptive use. This should be part of a multimedia approach including support to regional IEC programs. (p. 19)
6. USAID, MOH, and the NPC should work together with the GSMF and GBC to enable greater freedom of advertising over GBC or competing networks. Marginal changes should be made in advertising messages but without compromising effectiveness. Pre-testing with leadership audiences should be more thorough. The participation of dissenting groups should be actively solicited to secure their understanding and support. (p. 19)
7. The MOH and CAs should move as soon as possible toward approval of the National Family Planning Services Guidelines, their dissemination, and their inclusion in refresher training for service delivery personnel. This should be accompanied by further dissemination of the GDHS and the Situation Analysis. Trainers also require refresher training. (p. 19)
8. USAID, MOH, and relevant agencies should plan to repeat the CBS before the end of FPHP, the DHS before the midterm evaluation of The GHANAPA Project, and the Situation Analysis within two years of the adoption of the National Family Planning Services Guidelines. MOH and JHPIEGO should proceed immediately with the publication of the

nurse training evaluation and continue current efforts to develop a training needs projection model and a training database. (p. 19)

9. The MOH should assure that funds available from the last NPA disbursement are used to a) support MCH/FP outreach and b) improve physical facilities, supplies, and the equipment situation, especially in the facilities where IUD insertion and/or VSC are contemplated. (p. 34)
10. An in-depth study should be conducted to review the feasibility of and options for the integration of the FPHP-funded CBD program into PPAG. Any further agreement to support community-based interventions should take into account the comparative advantage of NGOs, be based on performance, and include a minimum package of in-kind or financial incentives and facilitating supervision. Also, a retreat should be organized to develop a strategy to improve the coordination of the MOH outreach activities and the CBD programs. (p. 34)
11. AVSC, GRMA, and the MOH, in consultation with JHPIEGO, should develop a more institutionalized approach to quality assurance for long-term methods. The objectives should include monitoring training; advocating facility improvement; conducting continuing education; improving IEC and medical surveillance to assure proper counseling, informed and voluntary choice; availability of other methods; availability of equipment and supplies; and proper medical technique and assessment of reported medical problems. Consideration should be given to using the return to project fund of the MOH for financing such actions including institutional reimbursement for surgical cases. (p. 34)
12. GSMF should either a) renew its efforts to seek another distributor for the non-traditional market or b) experiment further with a limited in-house sales staff to enter this market and participate in additional promotional activities in support of all distributors. GSMF should accelerate personnel actions and training to manage additional activity and assure institutional sustainability at the project's end. (p. 35)
13. USAID, in collaboration with CAs, should identify project-funded activities that support MOH efforts to strengthen general management and technical skills at the district and community level. USAID should include the monitoring responsibilities for this in the Scope of Work of one of its staff members. (p. 42)
14. As appropriate, HIV/AIDS specialists should be included in relevant coordinating bodies of family planning and HIV/AIDS-prevention programs, as well as in private and public institutions supporting family planning and HIV/AIDS interventions, in order to ensure that HIV/AIDS issues are taken into consideration in major decision making. These bodies and institutions include: NPC, PACC, GSMF, and USAID. (p. 42)
15. Before the departure of the long-term advisor, the PHRL should prepare a briefing document on the work accomplished under FPHP and the challenges faced by the Health Laboratory Services. This document should detail the additional support needed to increase the sustainability of the rehabilitated laboratory network, including long-term training and the implications of recurrent costs. This document should be presented to other donors with the endorsement of the MOH and USAID. (p. 42)

16. The Noguchi Memorial Research Institute should concentrate on completing the two studies under way and abandon the study related to the natural history of HIV-2. USAID/Ghana should assist the Noguchi Memorial Research Institute to identify linkages with U.S.-based institutions interested in its research program. (p. 42)
17. TAC meetings should facilitate GOG ownership of FPHP. The TAC should be the mechanism through which GOG representatives design, monitor, and review FPHP implementation, with budgeting as a component of the larger activity. (p. 52)
18. Within the MOH, officers with responsibility for approving expenditures and unit heads with implementation responsibilities should work together to eliminate expenditure approval delays. (p. 52)
19. The MOH should have greater participation in the selection and timing of short-term technical assistance visits. Provision of resumes and better consultation regarding timing of visits would help accomplish this. (p. 52)
20. MOH return-to-project funds should be used to procure consumables for VSC procedures. (p. 52)
21. The institutional contractor should provide TA to the MCH/FP unit and, through collaboration with PPME, demonstrate how service statistics can be used at decentralized levels to improve self-assessment, supervision, and management. These data report essential GHANAPA conditionalities. (p. 52)



# 1 INTRODUCTION

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## 1.1 Project Description

This report documents the final evaluation of the Ghana Family Planning and Health Program (FPHP), a bilateral agreement between the Government of Ghana (GOG) and the United States Agency for International Development (USAID). The six-year, US\$30 million project agreement was signed in April 1991. An amendment for a four-year subproject for HIV/AIDS was signed in August 1991, adding US\$5 million. The project completion date is March 31, 1996.

The Family Planning and Health Program consists of three components: non-project assistance (US\$13 million); the Family Planning and Health Project (US\$15.5 million); and contraceptive procurement (US\$6.5 million) through the Contraceptive Procurement Project. The purpose of the total program is to lower fertility through maternal and child health (MCH) interventions and reduce the spread of HIV/AIDS.

The non-project assistance (NPA) component consists of economic assistance to support the GOG's efforts to increase the demand for and use of modern methods of family planning, through expanding the capacity of the public and private sectors to provide services, supplies, and information relating to family planning (FP) and MCH. The project components include demand generation through intensive educational efforts, training, and advertising; delivery of contraceptives and other health-related services and products with particular emphasis on social marketing of condoms, oral contraceptives, and vaginal foaming tablets; improved logistics systems; support to the clinical laboratory system; and monitoring through management information systems (MIS) and HIV serosurveillance.

The program was originally designed as an MCH/FP activity; however, it became apparent late in the design process that a target of opportunity had emerged through which USAID could help strengthen the physical infrastructure and human resources needed to support the GOG's expanding HIV/AIDS control program. This built on prior USAID support channeled through the World Health Organization (WHO) to support the nascent Ghana National AIDS Control Program (NACP) and from 1988 through 1992, US\$1.3 million provided through AIDSTECH and AIDSCOM.

A program amendment was prepared that included support to national laboratories, technical training, and serosurveillance, as well as information, education, and communication (IEC) and nongovernmental organization (NGO) activity for behavior change and condom use. The late addition of these activities explains why most function as relatively discrete projects, with less interagency coordination than is evidenced by other project parts. (The exception being IEC activities which are cross cutting.)

Two program activities are not discussed in this report. While it was originally planned to include chloroquine as a component of the Ghana Social Marketing Program (GSMP), it was determined that sufficient quantities of the product were available in the market, and it was decided rather to support existing Ministry of Health (MOH) information campaigns to improve treatment compliance. The GSMP was also meant to include oral rehydration sachets in its

program, but it encountered numerous obstacles in securing the raw materials from a local packager. This has only recently been resolved.

The program was carried out through several implementation modes. The FPHP Program was administered by the Ministry of Finance and Economic Planning (MFEP), with responsibilities for program activities mainly delegated to the Ministry of Health. The FPHP Project was implemented through an institutional contract with The Futures Group International (Futures), the International Science and Technology Institute (ISTI), and the Center for Communication Programs at Johns Hopkins University (CCP), and a cooperative agreement with the American College of Nurse Midwives (ACNM); buy-ins to centrally-funded projects, including the OPTIONS Project, Demographic and Health Surveys (DHS), and AVSC International; and project support. In addition, other projects carried out activities using central USAID funds, including the Family Planning Logistics Management Project (FPLM), Family Health International (FHI), the Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO), and The INTRAH Project. While the agreement with the GOG was signed in April 1991, the institutional contract was not signed until September 1992. The Futures Group Chief of Party arrived in October, followed soon after by two long-term advisors.

FPHP established targets that addressed the USAID/Ghana Mission's strategic objective of reducing Ghana's fertility rate. These included lowering the total fertility rate (TFR) from 6.4 in 1988 to 6.1 by 1996 and slowing the annual rate of population growth from 3.4 to 3.0 percent by 2000. This is to be achieved by increasing contraceptive prevalence of modern methods from 5 percent in 1988 to 15 percent by 1996.

The goal of achieving a drop in total fertility has been met and exceeded. The 1988 Ghana Demographic and Health Survey (GDHS) measured a TFR of 6.4; the 1993 GDHS indicated an overall TFR of 5.5. Differentials persist by place of residence and education. Rural women have a TFR of 6.4 children compared to four children for urban women, and women with no education have 6.7 children compared to only 2.9 for women with at least a secondary education.

Contraceptive prevalence among married women surveyed in the 1993 GDHS was 20.3 percent for all methods and 10.1 percent for modern methods. Analysis of data from the May 1993 Consumer Baseline Survey (CBS), the 1993 GDHS, and service statistics of the MOH, the Planned Parenthood Association of Ghana (PPAG), and the Ghana Social Marketing Program/Foundation (GSMP/F) indicates that the increased level of contraceptive prevalence should be nearly achieved by the end of the project, if the current pattern of contraceptive uptake continues.

Achievement of other project outputs will be discussed in the relevant sections of this report. Appendix 4 summarizes progress in achieving End of Project Status (EOPS) Indicators.

To consolidate gains made through the support of FPHP, USAID/Ghana has already designed and implemented a follow-on bilateral program with the GOG, the Ghana Population and AIDS Project (GHANAPA). GHANAPA is a US\$45 million combined non-project assistance and project assistance effort to increase contraceptive prevalence to 20 percent, shift the method mix from 20 percent to 40 percent long-term methods, and increase awareness and practice of HIV/AIDS risk reduction behavior by increasing the use of condoms and improving knowledge of HIV infection prevention. The evaluation team is aware of the activities to be carried out

under this project, and some references will be made to implications of FPHP performance for the implementation of the new project.

## **1.2 Evaluation Methodology**

The Scope of Work (Appendix 1), identifies the objectives of the evaluation:

- Describe the current status of the program
- Identify and analyze accomplishments and problems
- Assess institutional and management arrangements

The evaluation team was also asked to provide "specific, prioritized, and justified recommendations" for improvements through the end of the program.

In part due to the full engagement of USAID/Ghana staff in the development of GHANAPA, a midterm evaluation scheduled for the final quarter of 1994 was postponed. It was subsequently decided to forgo a midterm evaluation and instead advance the timing of the final evaluation. In this way, Mission staff can apply lessons learned under FPHP to make improvements in planned and ongoing activities scheduled to take place under GHANAPA, before the new project is far into its implementation. This evaluation also fulfills the administrative requirement for a close-out evaluation. It must be kept in mind that the program will continue for 10 months beyond the date of the evaluation fieldwork, and thus some benchmarks not yet achieved may be met by the actual conclusion of the program.

The evaluation team included four members. Dr. Susan Adamchak served as the family planning policy specialist and as team leader. Mr. William Bair assumed responsibility as the family planning program specialist, and Mr. Cliff Olson was the management specialist. Dr. Souleymane Barry, of USAID's REDSO/Abidjan office, served as the AIDS program specialist. Fieldwork was carried out in Ghana for four weeks, May 1-27, 1995.

The team used several methods of data collection and analysis. A comprehensive document review was carried out (see Appendix 2). Interviews were conducted with more than 175 respondents from the public, private, nongovernmental sectors, multilateral and donor agencies, and Cooperating Agencies (Appendix 3). Site visits were conducted in five of Ghana's 10 regions: Central, Eastern, Ashanti, Brong Ahafo, and Greater Accra.

The team also made database searches and analyzed service statistics and budgetary data. Finally, additional input was sought from implementing organizations at two open meetings held during the first and third weeks of the assignment. Debriefings were held during the final week with USAID staff and implementing organizations during which key findings and recommendations were discussed.

## **1.3 Report Format**

This report contains seven chapters. Chapter 2 describes the population and family planning policy environment within which the program was implemented. Chapter 3 summarizes issues

pertaining to family planning demand creation, while Chapter 4 considers supply of services through the public, private, and NGO sectors. Chapter 5 reviews activities undertaken in support of HIV/AIDS prevention and control. Chapter 6 examines issues of program management and implementation, effectiveness of contractors, and logistics management. The final chapter presents conclusions and lessons learned.

Background narrative and information describing program components has been deliberately kept to a minimum in this report. The team has been able to do this in part because there is substantial documentation available that provides historical and developmental information. Readers are referred to Appendix 2 for sources of detailed information.

## 2 THE POPULATION AND FAMILY PLANNING POLICY ENVIRONMENT

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### 2.1 Introduction

The evaluation Scope of Work requests that the team consider policy issues ranging from the macro, national level to the operational, service delivery level. Among the issues identified are the following:

- Whether NPA functioned well as a means to accomplish policy reform
- How to ensure that the National Population Council (NPC) Secretariat is capable of managing its growing agenda
- How to ensure that the NPC Secretariat is capable of coordinating population activities in Ghana

The team was also asked to investigate progress on implementation of the population policy agenda and consider operational policies that restrict access to family planning or AIDS services, particularly through provider bias or inappropriate restrictions.

### 2.2 NPA as a Means to Accomplish Policy Reform

#### 2.2.1 Status

In the case of the FPHP, the NPA appears to have been an appropriate mechanism to spur policy reform, both at the level of national population policy and at the level of operational reforms affecting the availability and accessibility of family planning services. All Conditions Precedent (CPs) set as terms for tranche releases under the NPA were met, albeit late for each tranche.

TABLE 1

EXPECTED AND ACTUAL DATES OF ACHIEVING TRANCHE CONDITIONALITIES		
Tranche Number	Expected Date	Actual Date
Tranche 1	October 25, 1991	January 24, 1992
Tranche 2	October 25, 1992	December 15, 1992
Tranche 3	April 25, 1994	January 15, 1995

While the delays in achieving the CPs had a relatively slight effect on the policy changes made by the GOG, the projects that obtained funds from the NPA local currency account suffered more acutely (discussed in Section 6.2).

The program outputs listed in Table 2 serve as benchmarks for performance in the policy arena. These are appropriate indicators for the policy development and promulgation stage. Other indicators are needed to assess the impact of policy implementation. Some alternatives are presented in Appendix 5.

TABLE 2

<b>STATUS OF NATIONAL AND OPERATIONAL POLICY BENCHMARKS</b>	
Program Assistance Outputs	Date Completed
VFTs, ORS, and chloroquine exempted from regulations under Pharmacy & Drug Act (Tranche 1 [T1])	October 1992
OCs reclassified to permit distribution by providers with MOH approved training (T1)	January 1992
OCs designated as Class C "other" drugs; VFTs added to EDL (T1)	January 1992
EDL expanded to include all OCs (Tranche 1 [T1])	January 1992
Duties eliminated for imported contraceptives, ORS, chloroquine (T2)	October 1992
NPC established, funded by GOG (T2)	November 1992
Price controls removed from contraceptives and related drugs (T3)	1992 Budget
National implementation plan developed, adopted, and promulgated (T3)	Approved by NPC, June 1994
Procedures for review of demographic goals established (T3)	Implementation Plan, July 1994

Important accomplishments include the establishment of the National Population Council by legal instrument, Law 485 of 1994; the preparation of a comprehensive set of action plans for policy implementation that have already been used in the development of new programs; and the reclassification of contraceptive products to be legally offered by a wider array of distributors.

Institutional memory within USAID, MOH, and MFEP is short, due to staff turnover and reassignment, but it seems clear that the population policy reforms included as NPA CPs were drawn directly from Ghanaian sources, most notably the 1986 "Legon Plan of Action on Population" and the report of the 1989 National Population Conference held to commemorate the twentieth anniversary of Ghana's population policy, "Ghana Population Policy: Future Challenges." The latter document is a blunt assessment of the lack of progress in achieving any of the goals set out in the 1969 population policy. Conferees called for the establishment

of a National Population and Human Resources Council (NPHRC, later called the NPC) "to be responsible for coordinating and directing all population and human resource activities in the country" (Social Sector Policy Unit, 1991, p.25). They also recommended the establishment of a secretariat to service the NPHRC. Both of these recommendations were implemented through the support of the NPA.

The operational policy reforms sought were more directly promoted by the MOH and USAID, based on experiences with barriers to service delivery and commodity distribution found during the Contraceptive Supplies Project (CSP) and centrally-funded activities.

Some complaints were voiced by NPC staff and MFEP colleagues about the timing and pace of undertaking some NPA activities, notably the preparation of the action plans. Nevertheless, five years had passed since the recommendations were made in 1989. Had action not been taken, Ghana would continue to drift toward a third decade of apathy in the implementation of its population policy.

### *2.2.2 Problems*

It appears that the same policy ends might have been accomplished with less antagonism had USAID been more communicative about its expectations regarding evidence of CP compliance and had the GOG been more timely in its efforts to achieve the CPs. The team recognizes that a number of delays were due to events beyond the control of either party to the agreement, most notably the change of government in 1994 to a parliamentary democracy, necessitating different bureaucratic procedures.

There is a wide range of opinion among GOG counterparts on the purpose of NPA. While the CPs were for the most part derived from locally generated concerns and priorities, a sense of ownership of the process and its results is lacking. One disgruntled respondent referred to NPA as a stick with which to hit Ghanaians over the head, rather than a tool to encourage policy dialogue. At the same time, program staff thought NPA served a useful role in forcing policy-makers to undertake change. The burden now falls to the Secretariat of the National Population Council and GHANAPA implementors to monitor policy interpretation and application.

## **2.3 NPC Capacity to Manage Agenda**

### *2.3.1 Status*

The National Population Council is comprised of about 21 Ghanaians active in population, health, social services, law, and other disciplines. It is chaired by Dr. Fred Sai, an internationally known population expert. Its program is implemented by a Secretariat, temporarily chaired by the Social Sector Policy Unit (SSPU) of the MFEP, among its other duties. The Secretariat is supported by five Technical Advisory Committees (TACs), with membership drawn from both public and private sectors, local universities, and NGOs.

Under FPHP the NPC Secretariat obtained support for renovation; office equipment, computers, and vehicles; and training for two staff members in IEC and data collection. NPC

was instrumental in coordinating the preparation of the six-volume "Revised National Population Policy Action Plan" (1994) by technical subcommittees of the TACs (with support from The OPTIONS Project). The NPC also participated in the design and development of The GHANAPA Project.

### *2.3.2 Problems*

NPC capacity to manage the population and family planning agenda is not yet assured. Indications are that it is poised to do so, but many hurdles have yet to be cleared to ensure its success. Most seriously, senior staff members have not been appointed to the Secretariat, nor has a decision yet been made in the president's office as to who will represent the NPC in Cabinet level meetings. Less significant, but disruptive nevertheless, is the fact that the NPC is not yet installed in its office facilities, with the attendant benefits of appropriate work, meeting, and storage space and equipment. These are ongoing problems that have been cited repeatedly for more than two years.

It appears that infrastructure questions will soon be resolved. Renovation of an existing building previously occupied by the Ghana National Family Planning Program (GNFPP) is under way and projected to be completed by May 30. While the evaluation team did not have a building contractor among its members, its observation of the work remaining to be done causes it to doubt that the target date will be met. It is also possible that if work continues at a steady pace, it should be completed soon.

Personnel appointments remain problematic. Job descriptions were prepared for the executive director and four directors of divisions, positions advertised, and interviews conducted. Candidates were submitted to the Public Services Commission (PSC), which sent appointment letters to the selected candidates in 1994. However, with the passage of the bill establishing the NPC, it was determined that to be properly implemented, appointments of senior staff must be made by the president of Ghana. Thus, the original letters were withdrawn in order to be issued again over the signature of the president. In effect, this also nullified the completion of conditions for tranche 3 of the NPA. (Also, the candidate identified to head the IEC division has since accepted another position and withdrawn from consideration.) At this time an alternative candidate for the position of executive director was proposed. This candidate did not fit the job description for the position, having no background in population or demography. His nomination was protested by the chair of the NPC, and the result has been a stalemate that has lasted for months.

USAID is not the only agency concerned with the apparent lack of commitment on the part of high government officials to this issue. The evaluation team was told that Nafis Sadik, director of the United Nations Population Fund (UNPF) raised this issue with President J.J. Rawlings during a recent visit. The president was evidently unaware of the problem, and when clarification was requested from an advisor, Dr. Sadik was assured that the matter would be resolved "by the end of the year." This timing is disturbing, for the NPC Secretariat cannot jeopardize its authority if its staff remains in an interim status for another seven months.

The ambivalence that surrounds the full establishment of the NPC Secretariat may indicate that the body was set up mainly to meet the FPHP CP, with insufficient "ownership" on the part of the GOG. To the extent that GHANAPA relies on the Secretariat as a coordinating and

advocacy body, it is important to ensure GOG commitment to it before additional resources are allocated.

## **2.4 Coordination of the Population Program**

### *2.4.1 Status*

Much to its credit the interim NPC Secretariat was able to successfully harness the energies of five multi-sectoral teams in the preparation of the "Action Plans for the Revised National Population Policy," completed in 1994. The process contributed to a better understanding of population as an integral component of development planning that spans sectoral interests. It also helped to formalize relationships among the participants who had previously been informal and *ad hoc*. The Secretariat was also responsible for preparation of the Ghana Country Paper presented at the International Conference on Population and Development (ICPD) held in Cairo in September 1994.

The GOG has an improving spirit of cooperation with the nongovernmental sector, which is important given the number of non-public organizations active in primary health care (PHC), HIV/AIDS, and family planning. It appears as if there is still an uneasy relationship with the private sector, but points of cooperation and complementarity are slowly taking hold, and the activities of the NPC will be important to foster better relations.

It does not appear that the NPC Secretariat is optimizing the expertise of its TACs on a routine basis. It remains to be seen whether it will successfully utilize the Population and AIDS Coordinating Committees (PACCs, one technical and one policy), charged with oversight of GHANAPA. While it was anticipated that the PACCs would focus on technical and policy issues, they have been spending much of their time during their first month of operation discussing the fulfillment of CPs.

### *2.4.2 Problems*

Full support and exploitation of the expertise of the NPC TAC members is one way to facilitate sector coordination. Ghana is one of few African countries to have such a wealth of local professionals active in the population and health fields, both nationally and internationally. It is incumbent on the Secretariat to make optimal use of this skilled manpower in shaping the agenda for policy implementation and coordinating the service delivery, training, and research of the many organizations engaged in program activities. The performance of the TACs during preparation of the action plans demonstrated their value, but there is no plan to draw on their skills in a routine, systematic way.

Little has been undertaken yet to consider means to decentralize NPC activities. NPC is waiting for a consultant's report (funded by UNFPA with some technical input from OPTIONS). A literature review has been completed, and a draft questionnaire designed to be used in studying district structures.

## **2.5 Progress on the Policy Agenda**

### *2.5.1 National Policy*

The NPC has as its top policy priority the reduction of fertility in Ghana. To that end, it assumed the lead role in the revision of the moribund 1969 National Population Policy and the development of policy action plans, and it is preparing to coordinate multi-sectoral programs in implementing the action plans. Through its advocacy on behalf of the GOG, the NPC Secretariat has worked closely with donor and international agencies to secure resources needed to support these programs, notably participating in the development of GHANAPA and the UNFPA Third Country Program.

### *2.5.2 Operational Policies*

Several policy issues create problems for demand generation and service provision. These include restrictions on the distribution of oral contraceptives and the influence exerted on open advertisement of contraceptive products by the conservative government monopoly of the media.

During the course of FPHP, awareness of both inconsistent interpretation of clinical precautions and cultural and personal biases of providers regarding age and parity of contraceptive users has greatly increased. In part this is due to the attention given to the 1993 Situation Analysis of Service Provision, carried out by the Ghana Statistical Service (GSS). A secondary analysis of the Situation Analysis (SA) data was subsequently carried out by GSS in conjunction with FHI. Based on "barrier scores" created to measure service practices and restrictions, a survey of providers was conducted in October 1994 in order to obtain a more precise picture of why providers adhered to some inappropriate practices.

Both studies yielded irrefutable evidence of provider bias and misinformation, and the MOH took action to ameliorate the situation. Two important activities undertaken were the presentation of five workshops on contraceptive technology updates and the preparation of National Family Planning Services Guidelines, soon to be followed by service protocols. While the workshops and Guidelines were supported with central funds rather than FPHP funds, it is fair to say that activities carried out under FPHP built the foundation for the recognition of this impediment to service provision.

The draft Guidelines are a great step forward in making contraceptive services more accessible. Services are to be available to all, with much less restrictive medical proscriptions. Of particular importance is the recommendation to allow traditional birth attendants (TBAs) and community-based distributors (CBDs) to both initiate and distribute oral contraceptives. Despite this progress, discussions with trainers, program managers, and service delivery personnel at several levels of the system confirm there is still much to be done to eliminate service provider biases. Old attitudes concerning the "dangers" of hormonal contraceptives persist and keep these contraceptives from wide distribution.

## **2.6 Conclusions**

Significant policy reform has occurred in Ghana as a consequence of the fulfillment of NPA conditionalities. The challenge now is to monitor the effect of these changes and assess whether they are indeed having the desired impact on increased family planning service delivery and accessibility.

Some respondents expressed hope in the developing role of the NPC, regarding the fact that government has taken the matter to Parliament for approval, put a structure in place, and prepared guidelines for administration as indicators of commitment. The legal framework is considered important as a means to limit institutional conflicts between ministries.

Nevertheless, there are signs that optimism regarding the role of the NPC has waned among many within the population and family planning community in Ghana. The NPC and its Secretariat must harness its resources and those of its colleagues in other sectors and organizations to lobby on its behalf to break the logjam impeding its full operation. Indeed, the lack of permanent staff assigned to the Secretariat is now jeopardizing the release of Tranche 1 funds under GHANAPA, as completion of all CPs of FPHP was among the first set of CPs for the new program. Of even greater importance is the question of representation of the NPC in the Cabinet. At the time of the evaluation, no resolution had been reached as to which member of the president's office will assume responsibility for the NPC, with authority to approve NPC activities up to a designated level before requiring Cabinet or presidential attention.

Roles, responsibilities, and working relationships also need to be defined and tested among ministries; central, regional, and district staff; and public, private, and NGO implementing agencies. In large measure the action plans identify agencies responsible for different activities, but questions remain. For example, the NPC is wrestling with the extent to which it should be identifiable at the district level. Perhaps a current member of the District Social Services Committee or Development and Planning Committee could assume local responsibility for NPC policy and programs. The chair of the NPC favors the evolution and testing of several models and flexibility in achieving NPC goals.

## **2.7 Recommendations**

1. USAID should review with the NPC Secretariat and the MOH the proposed structure of the NPC to determine if it is the best option to ensure successful implementation of the Secretariat role.
2. Major action is needed to staff the NPC Secretariat. Its legislative instrument should be reviewed and a determination made whether core staff must be appointed by the president. USAID should consider preparation and submission of a joint request for resolution to the president's office from donors and multilateral organizations involved in population, MCH/FP, and HIV/AIDS activities, although this raises the risk of an inappropriate appointee being installed.

3. The NPC Secretariat should identify a set of key indicators of the policy environment and Implementation and adopt them as measures of program status. The indicators suggested in the *Handbook of Indicators for Family Planning Program Evaluation* and illustrative evidence of their status in Ghana are presented in Appendix 4. Once indicators are identified, NPC should routinely monitor progress achieved. Updates on Indicator status should be included in the annual report and the proposed newsletter.
4. The NPC Secretariat should coordinate preparation of a technical agenda of issues of key importance to population, MCH/FP, and HIV/AIDS in Ghana and technical issues included in the PACC meetings. The findings of this evaluation should be included on the agenda of an upcoming PACC meeting.

## 3 DEMAND CREATION

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### 3.1 Introduction

The evaluation Scope of Work identified several elements of FPHP that can be considered elements of demand creation. These include the following:

- Information campaigns, advertising, and generation of support among opinion leaders
- Capacity building among service providers in the MOH, both at central and regional levels, including the adequacy of training
- Family planning counseling

An impressive amount of social science research has been conducted with FPHP support and its analysis has been important in shaping program activities. While not specifically addressed in the Scope of Work, some of the research and diagnostic activities are described below.

### 3.2 Survey Research and Site Reviews

#### 3.2.1 Status

Demographic and Health and Consumer Baseline Surveys. The Ghana Demographic and Health Survey and the Consumer Baseline Survey, both national surveys carried out in 1993, provide data on knowledge of various family planning methods and reasons for non-use or discontinuation. The CBS sample provided information germane to a commercial advertising campaign. While final reports were not published until early 1995, preliminary data were available for program guidance by late 1993 and early 1994.

GDHS results show that Ghana's family planning program is making good progress toward the FPHP goal of 15 percent modern method contraceptive prevalence rate (CPR), with an observed increase from five percent in 1988 to 10 percent in 1993. Using these data in a regression equation predicts that the total CPR should reach 26 percent in 1998. The CBS found a higher (14.8 percent) modern CPR largely due to a higher reported rate of condom use. Comparison of the two data sets found that both surveys provide comparable estimates of modern contraceptive use once condoms are excluded. The team recommends using the GDHS CPR estimate, as it is based on a larger sample and will provide a more accurate estimate of contraceptive use in the total population (Rutenberg, 1995).

The same study indicates that the decline in the TFR is greater than would be expected from the increased use of contraception, suggesting that abortion and many other factors, including use of traditional methods, may contribute to the decline in TFR. USAID is now considering two possible studies of the extent of abortion in Ghana. These are needed reviews, both from a public health standpoint and as a measure of demand for FP.

Situation Analysis. The 1993 Situation Analysis sampled 399 public and private service delivery points (SDPs). A preliminary report was discussed during a workshop for program leaders in late 1993, and USAID and MOH plan further dissemination of this data and that of

the GDHS in zonal seminars in 1995. The Situation Analysis revealed many conditions that compromise the quality of family planning information and service. For example, 23 percent of the SDPs had no family planning signs to indicate that services were available. More than half had no brochures, pamphlets, or information sheets, and three-fourths had no promotional materials.

More important were the conservative attitudes of service providers and the restrictions they placed on client eligibility for certain services. Nearly 90 percent of providers would not give any contraceptive method to a woman with fewer than three children. Many would not provide family planning to unmarried women or to married women without spousal consent. Requirements for frequent revisits and medical exams contribute to client dissatisfaction and discontinuation. As discussed in Section 2.5.2, the findings of the SA and its subsequent re-analysis and use in developing the provider bias study were important in spurring the development of standardized family planning guidelines.

Other Research. A 1993 survey explored the "Contraceptive Knowledge, Attitude and Practices of Private Sector Providers" (physicians, pharmacists, and chemical sellers). Its findings helped shape the organization of information and promotion activities in social marketing.

Site reviews by AVSC and JHPIEGO documented the need for improved facilities and equipment. These confirmed the findings of the SA which showed only 42 percent of facilities have running water, 42 percent electricity, and 68 percent toilets.

### *3.2.2 Problems*

Few problems emerged in carrying out the research activities. As is often the case, production of final reports experienced some delays, but preliminary data were available for program use.

## **3.3 Information Campaigns and Advertising**

### *3.3.1 Status*

Information and education activities address knowledge constraints identified in both the GDHS and the CBS. Among women surveyed in the GDHS, 91 percent knew about FP and more than 70 percent wanted to either space or limit their childbearing. However, only 10 percent were using a modern method of family planning. The results also showed that while overall levels of contraceptive knowledge were high, knowledge was generally insufficient and inaccurate. Rumors, myths, and health fears were widespread.

IEC activities are carried out by the MOH Health Education Unit (HEU) and its regional and district level counterparts. Advertising and promotional activities are organized by the Ghana Social Marketing Foundation.

### 3.3.2 Coordinated IEC Strategy Development

An outstanding effort to develop a coordinated national and regional public/private sector FP/HIV/AIDS information campaign was orchestrated by the HEU. The strategy provided for both national and regional focuses with mass media and interpersonal components. Regional health education officers (RHEOs) participated in the strategy design and a workshop to develop region-specific materials. The public sector was to focus on broad public health, HIV/AIDS, family health, and family economic issues, including generic information about various contraceptive methods. The private sector (through the GSMF) was to produce more specific advertising and promotional materials. A campaign was designed for HIV/AIDS with a neutral message intended to appeal to either contraceptive or disease prevention concerns. It is notable and unique that the campaign did not target high-risk groups, stressing rather that AIDS can affect anyone.

Public Sector. Full mobilization of the national campaign has not occurred. For example, 10 writers were trained to write FP, family health, and HIV/AIDS scripts for the Ghana Broadcasting Corporation (GBC) "Family Affairs" series. Sixty scripts were written and GSMF provided funds for their production. However, MOH funds were not available for their broadcast, due to delays in the release of NPA funds. One FP television commercial has been produced, "Helping You Make Healthy Choices," and is expected to be broadcast nationwide during May-June 1995.

Under the CSP project, "We Care," FP campaigns were successfully conducted in three regions, resulting in dramatic increases in the number of oral contraceptive users. FPHP called for similar campaigns in the other regions and maintenance efforts in the original three. Again due to restricted availability of funds, it was only possible to carry out a reduced scale campaign in two additional regions with no evaluation of the effort. Also, funds were not available to adequately mobilize the two to four community health nurses who are to be found in most level B SDPs anxious to engage in community outreach.

Nonetheless, substantial improvement was made in the institutional capability of HEU, notably in planning, strategy development, and materials design.

Private Sector. The advertising campaign of the GSMF proceeded with contracts executed with two advertising firms, Lintas and DAPEG. FPHP helped develop the capacity of these agencies by providing technical assistance (TA) through Porter/Novelli, Washington, DC. The two local firms have assumed the role of brand managers, directly involved in promotional activities as well as mass media advertising. Market research was used to develop strategies and materials and pre-test materials with target and leadership audiences.

While the materials are technically quite good, there may have been a flaw in the leadership audience testing or in efforts to elicit support and understanding from potential dissenting groups. A negative reaction came from a vocal minority that interpreted television ads as encouraging promiscuity. Part of the problem stemmed from the lack of legitimizing mass media support from the public sector. After two months the GBC (a government monopoly) bowed to criticism and canceled the ads. Agreement was finally reached to allow the ads to air after 10:00 p.m.

With mass media access constrained, GSMF has turned to other advertising media and promotional events. Point-of-sale (POS) advertising materials are prominently displayed in virtually all retail outlets. GSMF used an innovative approach in contracting with the Marketing Survey and Research Institute (MSRI) to have its nationwide network of field workers place the POS materials at these retail locations. Promotions at soccer games, discos and in cinema video spots as well as on billboards and posters have provided a substantial exposure of GSMF products to the urban populace.

Materials Produced. Considerable educational, advertising, and promotional materials have been developed by both the public and private sector or reprinted from previous programs (see Appendix 6). Most of those reviewed were eye-catching with a direct and understandable message.

### *3.3.3 Problems*

The lack of funds from NPA seriously hindered the regional campaigns and did not allow the participation of the public sector in the coordinated mass media campaigns as planned. This shortfall had a demoralizing effect on the personnel of HEU and the regional health education officers as well as reducing the community involvement that should have been generated from the regional campaigns. The lack of the mass media participation left much of the message unheard and the GSMF advertisements with inadequate legitimizing support.

The lack of community and leadership consensus on the degree to which advertising can deal directly with the issues of human sexuality and contraceptive use places a serious constraint on GSMF marketing activity. It is difficult to provide the advertising backdrop that creates retailer enthusiasm and activates the distribution system, creates brand recognition and loyalty, and stimulates consumer confidence. Also, it is hard to reach adolescents, poorly served by the present FP program but critically needing protection against sexually transmitted diseases (STDs), AIDS, and unwanted pregnancy.

Public sector materials were produced in such quantities that their scarcity in many SDPs suggests a problem with distribution. Evidently, the HEU remained optimistic that its funds would be released and delayed distribution in order to launch a concerted effort nationwide. While an understandable strategy, this resulted in limited materials being available in the SDPs. Distribution should receive further review.

## **3.4 Capacity Building, Training, and Counseling**

One of the most effective means to improve technical, clinical, and counseling skills is through training. More than 7,000 public and private sector trainers, communicators, and service providers were trained through FPHP programs (see Appendix 7).

### *3.4.1 Status*

Nurses and Midwives. A formal evaluation of this training will soon be published, but consensus among many program leaders is that the MOH/JHPIEGO courses for nurses and

midwives have been a major factor in the recent improvement in and increased utilization of FP services. While still emphasizing intrauterine device (IUD) technology, the courses were broadened at MOH initiative to include information on short-term methods and training in logistics, record keeping, infection control, and quality assurance. The curriculum developed with JHPIEGO assistance under CSP has now been officially adopted for nurse and midwife preservice training.

Voluntary Surgical Contraception and NORPLANT®. Thirty-five (exceeding a projected 24) doctor-nurse teams were trained in voluntary surgical contraception (VSC) between 1992-1994, and 15 hospitals were equipped to perform the procedure. NORPLANT® uptake has been slow, with 199 procedures completed in 1994. The new surgical site at Komfo Anokye Teaching Hospital (KATH) in Kumasi greatly enhances training for both VSC and NORPLANT® insertion. However, more attention to space is needed for trainee consultation and discussion to complement the excellent surgical facilities. Quality assurance includes counseling for informed client choice and the availability of all methods.

Private Midwives: Ghana Registered Midwives Association. Training private midwives has improved FP skills and contributed to the development of a stronger national and regional professional organization. The Ghana Registered Midwives Association (GRMA) now has 500 members; 127 of a planned 200 have received FP training under this project to date, adding to the 250 trained under CSP. In addition, 189 have participated in family planning updates, and 22 of a projected 45 have participated in JHPIEGO's IUD training. Their involvement in seminars, community support for FP, and advocacy for quality assurance is important beyond the 6,000 to 7,000 couple years of protection (CYPs) they provide yearly.

Traditional Birth Attendants. Training of TBAs during this and the previous project to a level of 4,025 TBAs made an important contribution to maternal and child health. An internal review of the project concludes that "The TBA is now more competent than before in managing deliveries, and maternal and early childhood deaths (from neonatal tetanus) are now a thing of the past." The same review brought out the lack of impact this training has had on family planning. On average each TBA supplies less than one CYP/year with condoms and foaming tablets. On the whole they were responsible for approximately 1,800 FP referrals in 1994. Only 27 percent of TBA clients heard about family planning from the TBA.

Pharmacists and Chemical Sellers. Nationwide training of pharmacists and chemical sellers was carried out in late 1994. Vendors who were contacted spoke highly of the course and had the excellent training manual on hand.

Community-Based Distributors. The Planned Parenthood Association of Ghana was contracted by GSMF to train CBDs identified by more than 10 NGOs. The training manual is not yet complete, but the course outline and didactic material is appropriate. CBDs indicated that the course was participatory, with emphasis on communication skills as well as concepts of family planning and HIV/AIDS. The knowledge level was high; nevertheless, CBDs' contribution to national CYPs remains negligible.

### 3.4.2 Problems

Lacking evaluation of several key training programs, it is difficult to assess the impact of these activities or to propose modifications. Overall, the training materials and schedules are appropriate, but the team was unable to assess the actual application of new skills beyond subjective impressions.

Several of the didactic and practicum trainers stated they had not had refresher training themselves in many years. With changes in MOH guidelines for family planning, a refresher course especially for in-service trainers and for nurse and midwife preservice tutors is needed.

The low sales output of NGO CBDs is less related to their training than to problems of supervision, contraceptive supply, and price.

## 3.5 Conclusions

There has been considerable social change in Ghana with indications that demand for family planning is growing. However, the increase in use of family planning services does not obviate the need for continuing emphasis on demand generation. Old attitudes about contraceptives die hard in the leadership and health care provider community. Misinformation and rumors must be corrected before the use of modern contraceptives becomes a social norm.

An excellent cadre of personnel in the HEU, the Regional Health Education Offices, and SDPs can carry out a comprehensive mass media and interpersonal IEC campaign if resources are available. Buttressed by the marketing skills of the GSMF and the communication skills of private sector advertising agencies, these personnel can make rapid gains in the quality of the FP/AIDS information program. Adequate funding must be assured for this essential program component.

Capable training institutions and trainers exist at every level to absorb and transmit the newest in contraceptive technology, family planning service delivery modalities, and management skills. Limited technical assistance, exposure to other programs, and refresher courses will be necessary, but the bulk of preservice and in-service training needs can be met in Ghana.

The need for evaluation of some components of the information program (e.g., training and the regional campaigns) is apparent. Furthermore, diagnostic and evaluative surveys must be repeated at appropriate intervals to coincide with stages in project development requiring evaluation benchmarks.

An ambivalence remains regarding the balance between the need for explicit and direct contraceptive information and the perception of stimulus to promiscuity. Family planning messages must be presented in an acceptable way but without compromising their effectiveness. The coordination between FP and HIV/AIDS communication is helpful in this regard. Efforts are required to gain the participation and coopt the support of dissenting groups. This issue should receive attention by the National Population Council to assure that all opinions are considered.

### **3.6 Recommendations**

5. The MOH and USAID should ensure that adequate funds generated from NPA are used to carry out substantial portions of the public sector IEC campaigns before project completion. Emphasis should be placed on mass media (radio and television) both to partially fill the gap of limited GSMF advertising and to legitimize the airing of increasingly specific messages about family planning and contraceptive use. This should be part of a multimedia approach including support to regional IEC programs.
6. USAID, MOH, and the NPC should work together with the GSMF and GBC to enable greater freedom of advertising over GBC or competing networks. Marginal changes should be made in advertising messages but without compromising effectiveness. Pre-testing with leadership audiences should be more thorough. The participation of dissenting groups should be actively solicited to secure their understanding and support.
7. The MOH and CAs should move as soon as possible toward approval of the National Family Planning Services Guidelines, their dissemination, and their inclusion in refresher training for service delivery personnel. This should be accompanied by further dissemination of the GDHS and the Situation Analysis. Trainers also require refresher training.
8. USAID, MOH, and relevant agencies should plan to repeat the CBS before the end of FPHP, the DHS before the midterm evaluation of The GHANAPA Project, and the Situation Analysis within two years of the adoption of the National Family Planning Services Guidelines. MOH and JHPIEGO should proceed immediately with the publication of the nurse training evaluation and continue current efforts to develop a training needs projection model and a training database.



## **4 SERVICE DELIVERY**

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### **4.1 Introduction**

In the area of service delivery, the Scope of Work for the evaluation mainly emphasized questions pertaining to the accessibility of services, whether the impact of CBDs was adequately assessed, and the effectiveness and impact of the social marketing program. Specific questions on social marketing concern the following:

- The effectiveness and cost effectiveness of the marketing strategy, the pricing policy, and promotional activities
- Whether the market research agenda was appropriate to design and implementation
- Whether sales targets were appropriate given project inputs, the socioeconomic situation, and experience of social marketing in Ghana

### **4.2 Service Accessibility: Delivery Points and Staff**

#### *4.2.1 Status*

Family Planning services are provided in a nationwide network of service delivery points (see Appendix 8). Many SDPs are minor providers but offer a point of contact with the community in nearly 18,000 locations in all 110 districts. MOH estimates that an additional 366 health centers are needed to meet the PHC guideline of one institution for every kilometer radius. With each outreach post covering three villages, 50 percent more than the present 5,880 outreach posts are required to serve all 27,107 villages. MOH institutions are playing an important role in extending services to the dispersed population. However, much more costly outreach is required to extend services to all communities. The Situation Analysis notes the present low number of FP clients in many MOH centers as compared to some private sector posts, substantially reducing their cost efficiency as family planning providers. Efficiencies can be gained by reducing consultations, examinations, and revisits, as recommended in the draft services guidelines.

Private sector SDPs such as pharmacies and chemical sellers play an important role in the extension of services but there are limits to their reach and their resources. The commercial incentive of product distributors does not and probably will not carry GSMF products to SDPs in the more rural communities where the market is limited for other products the distributors offer.

The conditions of the facilities as identified in the SA and the AVSC and JHPIEGO site reviews are a major source of concern, especially as emphasis is placed on a shift to more long-term (clinical) methods. Visits to SDPs in this evaluation demonstrated how service delivery is being improved in some locations. However, these visits were also a reminder of how much harder it is for even well-trained, well motivated personnel to provide quality service in inadequate facilities.

The MOH facilities are generally well staffed with personnel trained in MCH/FP skills. The skewing of personnel toward the greater Accra region is being addressed by a "no transfer to Accra" policy. The current level of 2,910 staff persons involved in MCH/FP could theoretically provide one community health nurse midwife and two community health nurses for each static facility, sufficient to carry out outreach to 12 points and supervise 10 TBAs. This encouraging picture also points to the continuing task confronting the MOH. There are formidable numbers of staff members who require continuing education if the most up-to-date FP technology is to be employed, new National Family Planning Services Guidelines assimilated, and the "provider biases" resolved.

The GSMF has trained sufficient chemical sellers and pharmacists so at least one person in each shop is knowledgeable about contraceptives. The preponderance of the active sellers in the Kumasi/Accra corridor constrains how far the commercial channel can reach geographically with self-sustaining costs. The realities of the commercial marketplace calls into question the stated goal of 10,000 total GSMF outlets.

#### *4.2.2 Problems*

NPA funding, despite delays, assisted the MOH to substantially increase family planning coverage. Training has been supported; regular supervisory and evaluative meetings have been held with regional officers; management information gives attention to family planning; and supervision and outreach has been facilitated. However, outreach and supervision are reported to still lack adequate funds to function well. The provision of an adequate supply of contraceptives and technical assistance in improving their ordering, storage, and distribution has substantially improved their consistent availability.

The MOH is doing many of the things necessary to place priority emphasis on family planning in an integrated MCH/PHC program through its policy statements, service delivery guidelines, and personnel practices. Locations visited and reports reviewed indicate that the Ghana MCH/FP program is being integrated to the extent that family planning is becoming a part of all the relevant activities of the health center. Additionally, the mutually supportive approach with which FP and HIV/AIDS are addressed is a positive influence on the development of both program areas.

### **4.3 NGO and CBD Participation in Condom Distribution**

#### *4.3.1 Status*

In addition to family planning needs, available evidence indicates that Ghana has an increasing prevalence of HIV/AIDS in the rural areas, making it even more important that inexpensive condoms be readily available there. In rural areas, condoms are mainly being distributed through the MOH facilities, supplemented by the limited outreach activities of the community health nurses and FPHP- and PPAG-supported CBD programs. Evaluation field visits and document reviews indicate that the MOH has a potentially important staff resource in its community health nurses for local outreach. Unfortunately, these young staff persons, many of whom are well trained in HIV/AIDS and FP and are also very dedicated, evidently lack

transportation and accommodation facilities in the more remote rural areas to increase their performance.

The FPHP institutional contract called for training volunteer CBDs identified by local NGOs. It was assumed that the NGOs would assume ongoing responsibility for supervision and support, while GSMF would use its network of distributors to supply the CBDs with condoms. Approximately 500 CBDs were trained since the effort began in May 1994.

#### 4.3.2 Problems

The impact of the CBD program is not being adequately assessed under current monitoring and evaluation efforts. During the FPHP evaluation, a number of problems came to light that should have been addressed sooner. Although FPHP considered the advantages and disadvantages of linking CBDs with the GSMF and concluded it was appropriate, many of the CBDs interviewed for this evaluation reported difficulty in selling the relatively expensive Panther condoms to their rural clients. This is one factor that explains the poor sales performance of the FPHP-trained CBDs: an average of 40 condoms per month were sold per CBD over a one-year period from the beginning of the program. There is evidence of substantial movement of condoms between sectors, with some CBDs getting supplies from GSMF and others buying them from local chemical shops or picking them up from MOH clinics. At the same time, some CBDs indicated that they occasionally sell their condoms to proprietors of local chemical shops.

The CBDs did not receive any significant technical or material support once they completed their training, with the exception of limited IEC materials and a few penis models. In addition, FPHP did not take into account the respective comparative advantages of the NGOs in the development and implementation of its training program; many of those with whom it worked had little or no experience with health, FP, or AIDS issues, or with supervising their outreach volunteers. Also, FPHP did not establish any expected result from the supported NGOs. Some linkages were initiated between CBD programs and the MOH on an *ad hoc* basis, mainly in identifying MOH staff members as resource persons for training activities.

In developing FPHP, an anticipated activity with PPAG was deleted when it was learned that the World Bank would be providing support under a new project. Unfortunately, this did not take place, and an opportunity to build on the 10-year experience of PPAG with CBD programs did not occur. The lack of collaboration with PPAG led, in some cases, to duplication of effort in some rural areas, with associated wasted resources. PPAG will receive support under GHANAPA, with activities scheduled to begin later this year.

With its emphasis on cost recovery and dependence on distributors who answer to their own corporate structure, GSMF may not be the most effective channel to supply contraceptives to the two small markets of CBDs and registered midwives. Consideration should be given to shifting the NGO/CBD program in its entirety or its supply to PPAG. Consideration should also be given to MOH and GRMA to develop a mutually acceptable system of supply.

## **4.4 Expansion of Voluntary Surgical Contraception**

### *4.4.1 Status*

AVSC is represented in Ghana by an office staffed with three professionals in Accra since 1993, continuing previously initiated activities. A part-time medical consultant based in Kumasi is responsible for quality assurance countrywide.

Early response to AVSC initiatives in Ghana was guarded, with an apathetic, if not negative, reaction at Korle Bu Teaching Hospital in Accra. Enthusiasm among the medical staff at the Komfo Anokye Teaching Hospital (Kumasi) was not matched by hospital administration support, and facilities provided there were inadequate. The picture today is considerably brighter and exemplified in the outstanding surgical facilities completed with FPHP support at Kumasi. Excellent facilities have also been completed in Koforidua, and the client response is slowly growing. Cape Coast will soon have similar facilities. Staff at Korle Bu Teaching Hospital in Accra continue to work in cramped quarters with shared operating rooms; however, the interest of the medical staff is considerably changed, warranting greater efforts to secure dedicated space.

Minilaparotomy with local anesthesia is performed in 23 public (and a few private) health facilities in the country, and the number of procedures has increased from 777 in 1993 to 1,154 in 1994. Performance at each site varies from a low of seven in one clinic to a high of 232 for Kumasi in 1994. NORPLANT<sup>®</sup> is provided at five sites with a total of 199 procedures in 1994. It is too early to predict whether this method will grow in popularity.

### *4.4.2 Problems*

The AVSC site assessment indicated considerable need for renovation, some of which has proceeded slowly with NPA funds. Some 50 sites in all regions are in various stages of repair, suggesting a more extensive spreading of resources than would be preferable with the rapid completion of a few centers of excellence in major metropolitan areas. It also underscores the need for an expanded program of quality assurance.

Acceptance rates for VSC are affected by the conditions of the facilities, the need to share space and supplies, the lack of knowledge or apprehension about the procedures in the community or among health care providers, and the newness of the procedures to many clients.

Physical facilities in many health centers do not guarantee quality services. Many women in Ghana are exposed to health or social conditions requiring special consideration for use of IUDs. Although a minor surgery, elective VSC must be provided in a setting that assures proper counseling and infection prevention. Discussions with leaders of AVSC and GRMA suggest that a more formal institutionalized approach to the issue would be useful. An organization, perhaps attached to AVSC, could be formed with the participation of AVSC, GRMA, and MOH. This organization could monitor training, advocate for improved facilities, provide continuing education, develop and promote information programs and referrals, assure adequate supplies and equipment through reimbursement, and provide medical surveillance for IUD and VSC procedures.

## **4.5 Support to Contraceptive Social Marketing**

### *4.5.1 Organization and Staffing of GSMF*

While FPHP support to the MOH was essentially the continuation and improvement of activities supported under CSP, the social marketing element entailed basic organizational change. Rather than continue with planning, monitoring, promotion, and sales resting with a single product distributor, a new management unit was developed.

The Ghana Social Marketing Foundation was formed May 20, 1993, about seven months after the institutional contractor team arrived. During this period the team fulfilled conditions to establish a legally constituted body satisfying both USAID and GOG requirements for administrative and fiscal responsibility.

GSMF prides itself on its lean operation dictated by the determination to become self-sufficient. GSMF operates with 16 subcontractors in advertising, packaging, printing, research, training, and distribution. With his training, business acumen, marketing experience and substantial Futures TA in social marketing, the executive director effectively leads this operation, supported administratively by Consultant Management Enterprise (CME), the FPHP project director, and the project executive secretary. Activities with the NGOs added one staff member to the FPHP team, who serves as a project coordinator.

Recently the requirements of a maturing program have moved GSMF to hire more staff. One person has been contracted to start sales of GSMF products in bars, filling stations, and other markets not traditionally open to the contraceptive trade. In October 1994 and in April 1995, two well-trained but relatively inexperienced staff persons were added to take over management of distribution and logistics contracts under the day-to-day tutelage of the executive director. Plans call for adding another professional to manage advertising and promotion contracts as the executive director assumes broader responsibility with the departure of the FPHP project director. The use of interns from the School of Business at the University of Ghana, Legon, is one possibility being considered.

### *4.5.2 Product Distribution*

Status. The GSMF approach to distribution has changed only slightly. DANAFCO remains the prime distributor of GSMF products with approximately 72 percent of sales. To stimulate competition and explore other outlets, GSMF chose two other distributors, STARWIN (also a pharmaceutical distributor), and Johnson Wax, a distributor of health aids and household products sold through a wide variety of outlets. These firms have 12 percent and 16 percent of the GSMF business, respectively. Although both DANAFCO and STARWIN claim to have distribution in all 110 districts of the country, the bulk of their trade is, like Johnson Wax, confined to a more metropolitan market between Accra and Kumasi. GSMF products are reportedly sold in 70-80 percent of the outlets served, but they do not make up more than three or four percent of the business of any one of these distributors. Business principles dictate that the distributors will use a marketing approach and geographic reach that is geared primarily to the requirements of their other products.

Johnson Wax takes an aggressive marketing stance with two professional marketers engaged in an expanding effort. Operating in two regions, it is moving into four more to service 60 districts. Johnson Wax reaches a broader market but does not have the penetration or geographic spread of the other two distributors. Working through three sales agents, its products are marketed by a sales staff of about 18. Its intent to expand and its satisfaction with joint promotional activities of GSMF and its own products show promise of further growth with this distributor.

DANAFCO is reportedly the third largest pharmaceutical distributor in the country. Its supplies products nationwide, but half of its business is in Accra, one-fourth in Kumasi, and the rest spread over the other eight regions. DANAFCO maintains depots in six major cities. Past practice required retailers to come to the depot for supplies. However, the company is increasingly sending sales staff to call on the trade and deliver. The number of outlets, to say nothing of the distances over poor roads, makes it virtually impossible to meet its stated goal of a 14-member sales force calling on most accounts biweekly.

STARWIN claims to be the fourth largest pharmaceutical distributor in Ghana, serving retail outlets in all districts with a sales force of only seven or eight representatives and agents.

GSMF is developing plans for training and sales incentives for sales agents to improve their sales techniques for all products, understand the GSMF products better, counteract negative reactions, and see "what's in it for them" to increase their emphasis on moving GSMF products.

Visits to more than 20 retail outlets confirmed findings from discussions with distributors and the 1994 retail audit. All outlets visited had POS materials prominently displayed. Most had GSMF products as well as a variety of other contraceptives secured from PPAG, MOH, and the social marketing program in Nigeria. Different stocking approaches are used: some buy from other shops, a few are visited regularly, and others are visited sporadically by one of the distributors. Most retail distributors had received training or said someone else in the shop had. Many had heard GSMF advertising, expressed satisfaction with the product, and reported growing sales. Stock-outs of one product or another are not unusual, and outdated Panther condoms were in stock in several shops visited.

Problems. GSMF has been unsuccessful so far in attempts to secure another distributor with nationwide sales of products such as beer, soft drinks, cigarettes, or soap in order to introduce contraceptives in non-traditional outlets. Johnson Wax partially meets this objective, but GSMF hopes to reach still more sales sites.

The major advantage of this distribution approach is the ability to capitalize on existing networks without being required to organize, supervise, and pay a parallel sales or distribution force. GSMF products, however, will go where other products lead at the same speed. Strong marketing and sales approaches have not been the hallmark of Ghanaian businesses, which for many years operated in a sellers market.

GSMF might consider supporting and supplementing the distributors' sales forces with more direct sales activities by a small in-house promotion and sales staff. A greater emphasis is already being given to promotional activities and alternative advertising in light of difficulties

with mass media advertising mentioned in Chapter 3. Results of an MSRI-implemented "advertising blitz" in May 1995 to all retail locations should be monitored.

#### *4.5.3 Development of a Cost-Effective Marketing Strategy*

Status. As noted above, the marketing strategy calls for a lean management style depending on contracts with other agencies for implementation. The strategy appears to be a logical, well-considered approach containing the standard consideration of market research, market segmentation, branded products, an increasing array of contraceptive as well as other health products, the expansion of the market through other distribution channels, and a variety of advertising and promotional ventures. The relatively slow growth appears to be due more to delays or difficulty in implementation than problems with the strategy itself. The strategy expected there would have been a greater policy shift regarding the distribution of oral contraceptives than was finally achieved through the NPA policy initiative. If sale of oral contraceptives were permitted in supermarkets and small shops, it is likely that sales would have increased dramatically as predicted in the strategy. The strategy counted on relative freedom to advertise, which did not prove to be the case. The inability to secure a "non-traditional" distributor with nationwide reach may be an initial failure of the market strategy to read and assess the market.

Problems. This approach is no doubt less costly than a strategy involving the development of in-house advertising, promotion, research, logistics, and sales capability. In the long run it may be more sustainable, as it does not need to completely stand alone. Sustainability, however, also requires generating a substantial market in a relatively short time. With the approach chosen, GSMF is burdened by the inertia of other established businesses that may not permit as aggressive or innovative an approach as would more in-house implementation. This approach also depends on such a limited in-house staff that any turnover could substantially disrupt the operation.

Given the dependence on other agencies for much of the work, it is even more important to develop research and monitoring tools to assure the effectiveness of the operation. Increased short-term technical assistance should be provided to help clarify research objectives and improve research design and analysis.

## **4.6 Social Marketing of Condoms**

The objective of social marketing of condoms was to achieve a private sector distribution of 24 million condoms. A review of the reported condom sales by GSMF, MOH, and PPAG indicate a continuing significant increase of condom sales. This is to be credited primarily to the MOH and secondarily to PPAG (see Graph 1).

Annual total unit sales volume through GSMF did not increase as expected since the beginning of FPHP, and, in view of the sales achievements of 15,571,000 condoms from April 1991 to December 1994, total unit sales will likely be short of the objective of 24 million by March 1996. The leakage of the MOH condoms to the chemical shops explains some of the sales difficulties. The retail audit commissioned by the GSMF indicated that "Sultan," "Gold Circle," and "other condoms" accounted for 28 percent of the average monthly sales of the

chemical shops and pharmacies throughout the country (see Graph 2). Had these sales been captured by GSMF products, an additional six million condoms could be attributed to the program. Sales figures are also counted from the date of the project signing rather than from the start of the institutional contract and full operationalization of the GSMF from September 1992.

## **4.7 Program Expansion**

### *4.7.1 Increase in Couple Years of Protection*

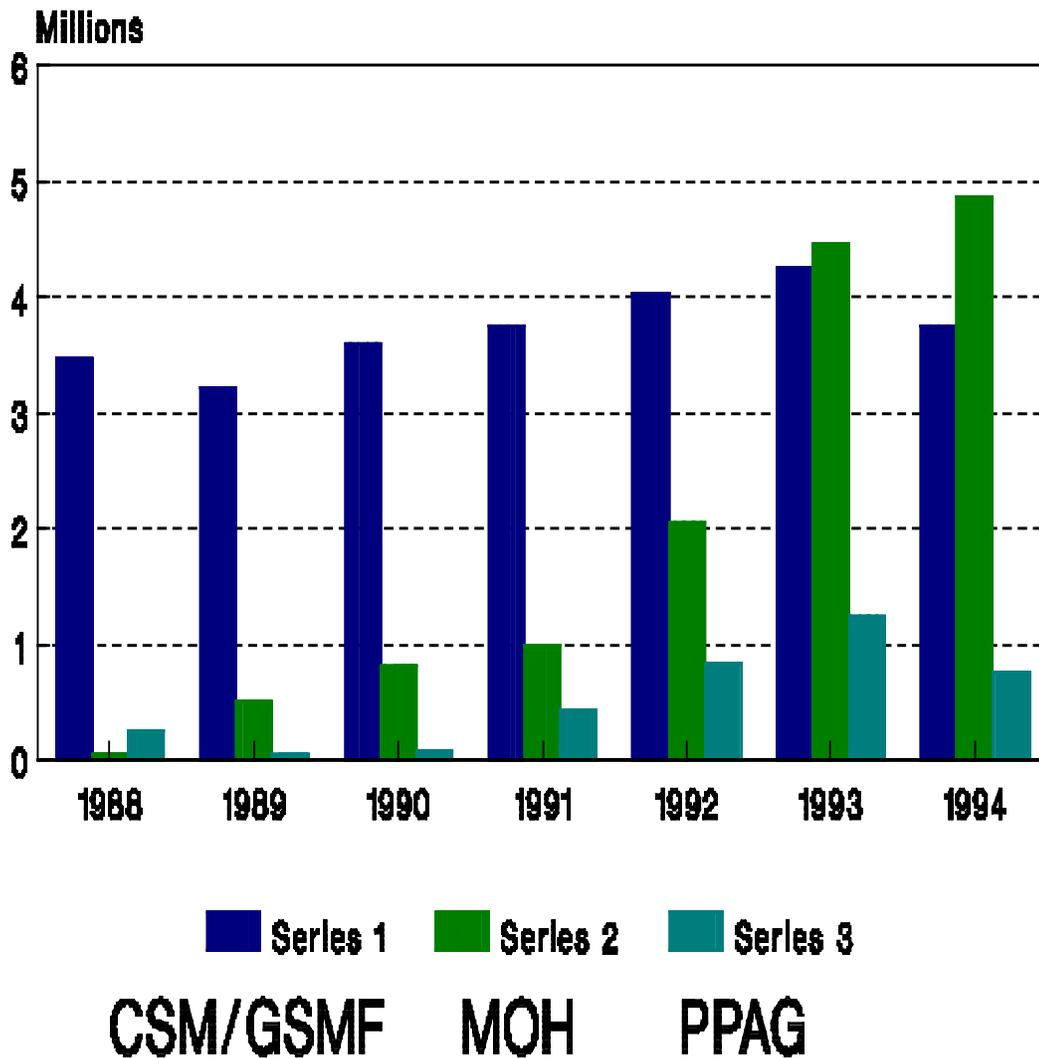
Graph 3, CYPs by Sector, 1986-1994, demonstrates the dramatic growth in contraception provided in this period, with the greatest increase seen in MOH services. FPHP anticipated a similar increase in the GSMF share, perhaps not anticipating the great shift to more longer-term methods (and their resultant higher CYPs) on the part of the MOH. As mentioned above, GSMF was also hampered by disrupted conditions at the end of The CSP Project, delays in start-up, the time required to set up the GSMF and its contractual relationships, the delay in training the retailers, and the constraints on advertising.

### *4.7.2 Method Mix: Long-Term versus Short-Term Methods*

Graph 4 of MOH long-term and short-term CYPs 1986-1995 shows the CYPs for long-term methods (IUD, injectables, NORPLANT<sup>®</sup>, and VSC) decreased in relation to short-term CYPs from 1991 to 1994, while increasing in absolute numbers; their steady growth was outpaced by increases in use of OCs and, to a lesser extent, condoms and vaginal foaming tablets (VFTs) (see Graph 5). Client choice is essential as Ghana expands services. Long-term methods are desirable for some clients and for program growth and continuity, but care must be taken not to place such emphasis on long-term methods as to result in their use in inappropriate clinical facilities with inappropriate clients, nor would it be prudent to downplay the contribution condoms will make to both HIV/AIDS and pregnancy protection. The new guidelines permitting a more barrier-free access to oral contraceptives may stimulate a desirable increase and a more consistent use of this method. GSMF is preparing its brand of Depo-Provera for the market, which will further meet local needs.

Graph 1

# Sales of condoms Through CSM, MOH and PPAG



Insert Graph 2

Insert Graph 3

Insert Graph 4

Insert Graph 5

#### 4.8 Conclusions

The MOH can provide family planning services to an increasing number of clients through its clinical services. Significant opportunities exist for outreach to more villages but will require logistics and supervisory support for outreach personnel; provider incentives; a supply and price structure that makes distribution functional at the lowest point; coordination with CBD activities of PPAG or other NGOs; and adoption of the less restrictive guidelines relating to oral contraceptives for these community personnel.

The MOH can achieve a measured expansion of the delivery of longer-term methods. This expansion **must** be accompanied by even greater emphasis on quality assurance, facilitated by cooperation with such organizations as AVSC, GRMA, and JHPIEGO. The concern for quality assurance should address facilities, equipment and supplies, training, counseling, medical surveillance, and IEC for all clinical methods.

The GSMF has demonstrated that its lean management approach to social marketing can continue a significant but only slowly growing share of contraceptive distribution in the country. Presumably the delays that hindered program growth are in the past. If the actions being taken to improve sales prove effective, the performance in the future will be more positive. However, acceleration and careful monitoring of the proposed actions between now and the end of project will be required to assure optimum performance.

#### 4.9 Recommendations

9. The MOH should assure that funds available from the last tranche of NPA are used to a) support MCH/FP outreach, and b) improve physical facilities, supplies, and the equipment situation, especially in the facilities where IUD insertion and/or VSC is contemplated.
10. An in-depth study should be conducted to review the feasibility of and options for the integration of the FPHP-funded CBD program into PPAG. Any further agreement to support community-based interventions should take into account the comparative advantage of NGOs, be based on performance, and include a minimum package of in-kind or financial incentives and facilitating supervision. Also, a retreat should be organized to develop a strategy to improve the coordination of the MOH outreach activities and the CBD programs.
11. AVSC, GRMA, and the MOH, in consultation with JHPIEGO, should develop a more institutionalized approach to quality assurance for long-term methods. The objectives should include monitoring training; advocating facility improvement; conducting continuing education; improving IEC and medical surveillance to assure proper counseling; informed and voluntary choice; availability of other methods; availability of equipment and supplies; and proper medical technique and assessment of reported medical problems. Consideration should be given to using the return to project fund of MOH for financing such actions including institutional reimbursement for surgical cases.

12. GSMF should either a) renew its efforts to seek another distributor for the non-traditional market or b) experiment further with a limited in-house sales staff to enter this market and participate in additional promotional activities in support of all distributors. GSMF should accelerate personnel actions and training to manage additional activity and assure institutional sustainability at the project's end.



## **5 HIV/AIDS PREVENTION AND CONTROL**

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### **5.1 Introduction**

The HIV/AIDS prevention and control component of the FPHP was designed and implemented in the context of a programmatic focus on family planning. The MOH and USAID were concerned with achieving the following HIV/AIDS project objectives in the most effective, timely, and cost-efficient means possible:

- Increased HIV/AIDS knowledge among the general population
- Three-fold increase in condom use to prevent AIDS
- Decrease in the number of sexual partners by 15 percent
- National laboratory network system in place providing efficient and accurate diagnostic analysis and generating data needed for epidemiological surveillance
- Formal health information system (HIS) in place to provide accurate and ongoing data to monitor prevalence of HIV infection and AIDS
- At least three ministries integrating the expanded AIDS prevention and control activities into their program
- At least 10 NGOs actively involved in providing HIV/AIDS information and education to identified target groups

The evaluation Scope of Work requested attention be paid to awareness-raising efforts among decision-makers; data collection and surveillance; development of laboratory facilities and training; management; IEC; and condom distribution.

### **5.2 Improved Knowledge and Behavior Change**

Data from the GDHS and the (CBS) have become available in the past 18 months that provide excellent information to use in determining changes in knowledge and behavior. Compared to the 1991/1992 National AIDS Control Program and WHO AIDS national survey, the CBS and GDHS data indicate that much progress has been accomplished by the NACP in maintaining high awareness of AIDS, improving specific knowledge of HIV/AIDS, and increasing condom use among the general population. While 61 percent of both men and women believed that HIV can be transmitted through insect bites in 1991/1992, only 37.5 percent held this belief in 1993. In addition, "persons reporting ever use of condom" increased from 24 percent in 1991/1992 to 40 percent in 1993.

Since 1993, FPHP has built on momentum gained in behavior change to develop a broad range of effective IEC and condom promotion activities in collaboration with other donors such as WHO/United Nations Development Program (UNDP), Overseas Development Administration (ODA), European Union (EU), and the German Association for Technical Cooperation (GTZ). It is likely that FPHP will meet objectives related to improving knowledge of HIV/AIDS and safer sex behaviors, and the CBS follow-up planned for late 1995 will provide data to assess progress.

### 5.3 IEC Component

The MOH, with technical assistance from Futures, managed to successfully integrate the IEC activities related to HIV/AIDS prevention into the core programs of the MOH, the social marketing program, and 18 NGO programs. In addition, the Ministries of Information, Education, and Mobilization and Social Welfare, and the Ghana Armed Forces (GAF) are involved in ongoing targeted IEC initiatives. These achievements were possible through a set of five measures:

- The collaborative development of a sound strategy and operational plans for integrated IEC interventions by the HEU, regions, GSMF, the MCH/FP Division, and NACP with the support of the institutional contractor
- The improved capacity of the HEU, regions, districts, GSMF, and NGOs to address HIV/AIDS issues through a series of integrated training workshops in FP, HIV/AIDS, and public health topics
- The transfer of the NACP's IEC specialist to the HEU in order to facilitate communication with the HEU and provide insight and HIV/AIDS focus in the ongoing HEU activities
- The continuation of HIV/AIDS and STD training activities conducted by the NACP with the support of other donors
- The continuing advocacy role played by the NACP at national and regional levels including the briefings for Parliament's Health Committee, regional medical directors, and journalists

These campaigns received multi-sectoral support including the following measures:

- The establishment of an inter-ministerial planning committee chaired by the Minister of Health with the active involvement of five ministries, religious groups, and NGOs
- The organization of numerous educational activities by MOH staff at regional and district levels and by the extensive network of about 1,350 FPHP and PPAG CBD agents
- The strengthened mass media support through broadcasts of AIDS and condom television and radio commercials, films, and talk shows

Five months after the AIDS awareness campaign carried out in November 1994, the evaluation team found ample evidence during its field trips that HIV/AIDS activities have become an integrated part of the ongoing MOH regional and district health education programs and NGO and PPAG CBD programs. Interviews with about 30 CBD agents supported by FPHP indicated that the CBDs have gained the necessary minimal package of HIV/AIDS information and guidelines.

## 5.4 Laboratory and Health Information System

### 5.4.1 Status

Although the building and equipping of three of the four zonal laboratories in Kumasi and Tamale and the regional laboratory in Sekondi/Takoradi are not yet completed, progress indicates this component will be achieved. The Accra branch of the Public Health Reference Laboratory (PHRL) is completed, equipped, and staffed with personnel trained for HIV testing and other public health services. It is anticipated that the remaining laboratories will be built, equipped, and functioning by the end of FPHP.

These achievements could not have been made without the dedication of the current leadership of the PHRL; the quality, commitment, and vision of the long-term technical advisor; and the good working relationships established with the NACP. In addition to monitoring the building, equipping the labs, and continually dealing with personality conflicts, the leadership of Health Laboratory Services (Dr. Asamoah Adu and his deputy Veronica Bekoe) and the long-term technical advisor have accomplished the following:

- Organized the Accra branch of the PHRL to provide HIV screening and confirmatory services throughout the year.
- Reviewed the condition and operation of more than 100 labs in all 10 regions.
- Reviewed the curriculum for the degree program for laboratory technologists and technicians of the Korle-bu Teaching Hospital.
- Developed a cadre of more highly trained laboratory personnel in all regions in both the public and private sectors. About 172 laboratory personnel were formally trained, including 40 from the private sector, in management, preventive maintenance, quality assurance, infection control, and budgeting.
- Established a system of continuing education of quality lab services in all 10 regions and developed relevant curricula.
- Established a functioning system for consistent supply of reagents for HIV testing throughout the country in collaboration with NACP.
- Established a laboratory resource center that includes a list of reference and text books and limited audio-visual equipment for training activities.
- Developed proposals for the licensure of laboratory personnel and accreditation of labs and a development plan for a "career ladder" for scientific officers and technical officers.

The training programs have created greater awareness and practice of infection and quality control and continuing education, as seen by or reported to the evaluation team during the field visits.

The establishment of the sero-surveillance system was considerably behind NACP's schedule for various reasons. Nevertheless, the 1994 HIV/STD surveillance report provides important information on the HIV/AIDS epidemic in Ghana. It will focus more attention on the Northern belt, whose median HIV prevalence is 2.4 percent and where HIV/AIDS was believed not to be a significant problem.

Other FPHP support includes discrete assistance to the GAF in laboratory diagnostic and HIV surveillance.

One computer was supplied to the Center for Health Information. Discussions were initiated with the new head of the division, who is presently taking important initiatives for the overall strengthening of the MOH HIS within the next five years in collaboration with the World Bank. Microcomputers for the regions and possibly vehicles would help strengthen the overall HIS.

The review of the TA package provided by the institutional contractor to the NACP and HEU for laboratory management and infection control indicates that most of the TA was very targeted and responded to real needs including the rehabilitation of the laboratory network of the MOH; review of the MOE's family life education curriculum; packaging of the NACP/WHO National Knowledge, Attitudes, Behavior, and Practice Survey (KABP) on AIDS for message development; and the adaptation of the AIDS impact model.

#### *5.4.2 Concerns for Maintenance of the Laboratory Network*

Some progress has been made in filling vacant personnel positions for various laboratory services of the MOH, but less than 40 percent of the approved positions are currently filled. The requested analysis to determine, before building the labs, the various options for the provision of laboratory services in the three additional regions of the country did not address cost and benefit aspects and did not receive appropriate attention of the FPHP Technical Advisory Committee.

Although a specific budget for the PHRL has been established, inadequate funding of its recurrent costs by the MOH is a major concern. There is also a chronic limitation of high-level expertise in laboratory management. This is a critical variable for the maintenance of the rehabilitated laboratory network. The need for long-term training in laboratory management is a pressing priority for the MOH.

### **5.5 Grant to the Noguchi Memorial Research Institute**

The FPHP also includes discrete support to the Noguchi Memorial Research Institute for HIV/AIDS-related research. To date, US\$103,500 of US\$229,608 was disbursed to support the implementation of three studies: research on the natural history of HIV-2 patients; testing local plants for effects against HIV-1; and identification of viruses from seronegative symptomatic patients. Implementation of all the studies is behind schedule, and it is likely that at least one—the study of HIV-2 patients—will not be completed. This project encountered difficulties in recruiting subjects: fewer cases of HIV-2 were identified than anticipated, and of those, not all individuals were willing to participate. Positive results include the testing of 15 plants to determine their effect against HIV-1, yielding some promising leads, and the identification of viruses from seronegative symptomatic patients that suggests the presence of viruses not detected by the standard HIV testing kits.

### **5.6 HIV/AIDS Issues in a Leading Population and Family Planning Program**

Despite the innovative and successful actions taken to effectively design and implement coordinated interventions, a review of two studies, the Contraceptive Retail Audit and the Contraceptive Pricing and Sustainability in Ghana (CPSG), indicates that HIV/AIDS concerns are not always taken into account in FP-related studies and recommendations that may affect an

HIV/AIDS control program. For example, the CPSG study considered the condom exclusively in the context of family planning although the condom is the most effective method for HIV/AIDS prevention and the least effective for FP. HIV/AIDS is not mentioned once in the report. The section, "Do Prices Affect Contraceptive Use?" may have been written differently if HIV/AIDS was considered. For example, following a price increase, if condom use drops "say only by 10 percent" among the estimated 700,000 condom users (high estimates), 70,000 in their most productive ages may risk becoming infected with a deadly virus. The 1991 WHO KABP survey also indicated that the younger groups may be the most affected by price increases: among the 15-24 and 25-39 age groups, 36.6 percent and 47.2 percent, respectively, indicated that condoms are "too pricey to use regularly."

## **5.7 Conclusions**

Under FPHP, the National AIDS Control Program has made important gains. HIV/AIDS activities are being integrated into the core programs of the MOH at the central and regional levels. Important steps were made to involve other sectors in the fight against AIDS and create a broad-based support for HIV/AIDS prevention and control. There are indications of significant improvement in specific knowledge on HIV/AIDS and condom use. In addition, FPHP has established the foundations for the rehabilitation of the Ghana laboratory network.

Despite the delay in the release of the NPA funds, the NACP accomplished a wide range of critical interventions. Its comparative advantage relative to the FP program is its support from such diverse donors as WHO, UNDP, EU, ODA, and GTZ. When NPA funds were delayed, NACP was able to turn to other donors to provide needed assistance.

The strategy developed by the MOH and FPHP to coordinate and integrate family planning and HIV/AIDS prevention and control activities has proven to be feasible and effective. This experience should be monitored carefully. The fact that women remain disproportionately affected by AIDS (69 percent of the AIDS cases as of 1994) provides an additional rationale for mutually supportive interventions. Clearly, it must be ensured that HIV/AIDS is taken into account in decision-making related to specific family planning concerns.

The advocacy role assumed by the NACP has been instrumental in the achievements made to date. In addition to advocacy, appropriate coordinated donor support of the MOH's decentralization and the development of broad-based multi-sector support for HIV/AIDS prevention and control are the critical elements for the effectiveness and sustainability of HIV/AIDS prevention and control interventions.

Many of the challenges faced by the NACP were identified and addressed during the design of The GHANAPA Project, including increased support for STD control. Special attention should be given to address the lack of coordination among the MOH's outreach activities, and FPHP- and PPAG-funded community-based programs. Other issues include the availability of condoms in the rural areas and the maintenance of the rehabilitated laboratory network.

## **5.8 Recommendations**

13. USAID, in collaboration with CAs, should identify project-funded activities that support MOH efforts to strengthen general management and technical skills at the district and community level. USAID, should include in the Scope of Work of one of its staff members the monitoring responsibilities for this.
14. As appropriate, HIV/AIDS specialists should be included in relevant coordinating bodies of family planning and HIV/AIDS prevention programs, as well as in private and public institutions supporting family planning and HIV/AIDS interventions, in order to ensure that HIV/AIDS issues are taken into consideration in major decision-making. These bodies and institutions include: NPC, PACC, GSMF, and USAID.
15. Before the departure of the long-term advisor, the PHRL should prepare a briefing document on the work accomplished under FPHP and the challenges faced by the Health Laboratory Services. This document should detail the additional support needed to increase the sustainability of the rehabilitated laboratory network, including long-term training and the implications of recurrent costs. This document should be presented to other donors with the back-up of the MOH and USAID.
16. The Noguchi Memorial Research Institute should concentrate on completing the two studies under way and abandon the study related to the natural history of HIV-2. USAID/Ghana should assist the Noguchi Memorial Research Institute to identify linkages with U.S.-based institutions interested in its research program.

## **6 PROGRAM MANAGEMENT**

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### **6.1 Introduction**

The evaluation Scope of Work identified three key management issues, including the following topics:

- The effectiveness of institutional arrangements, including performance of the institutional contractor, developments in institution building, and synergies with central projects
- The management implications of NPA and amount and use of locally generated funds
- Commodity logistics

Other management issues, such as the effectiveness of technical assistance and the impact of MOH decentralization, have been discussed in previous chapters.

FPHP consists of NPA, projectized activities, cooperative agreements, and USAID procurements. GOG management of FPHP occurs through the Technical Advisory Committee chaired by the International Economic Relations Division (IERD) of the MFEP and including representatives from implementing agencies and USAID. Additional management tasks are assumed by the institutional contractor for the projectized portion of FPHP, by the MOH for the NPA funds released to it, and by the USAID/Health, Population, and Nutrition Office (HPN) for buy-ins, grants to CAs, and purchase orders.

### **6.2 FPHP Management Arrangements**

#### *6.2.1 Technical Advisory Committee*

TAC meetings should facilitate GOG ownership of FPHP. The TAC should assume a more assertive role in planning and assessing programmatic activities to implement FPHP goals and objectives. Members have used the TAC as a forum to negotiate NPA budget issues, complicated by delays in the release of tranche funds. Implementing agencies repeatedly rebudgeted and reprogrammed for funds that did not arrive when anticipated. The TAC should take a more proactive position in reviewing the relative implications of proposed activities compared to the goals and objectives of FPHP and more aggressively search out alternative methodologies and less costly means to accomplish the intended results.

#### *6.2.2 USAID/HPN FPHP Management*

USAID/HPN has managed FPHP with increasing emphasis on the involvement of contractors, CAs, the GOG, and MOH. Weekly HPN meetings include representatives from contractors and CAs. These representatives report an appreciation for the complementarity of skills within the HPN office. The GOG and MOH, including officers at regional levels, report a sense of involvement in USAID population activities, particularly the design of GHANAPA. Buy-in funds, cooperative agreements, and grants have been expended in a timely fashion, exemplified by AVSC, the GDHS, and ACNM technical assistance to GRMA and the National Traditional Birth Attendants (NTBA) Program.

Current project expenditure information is included in Appendices 9 and 10. Early project implementation was delayed by the belated addition of the HIV/AIDs component, slow development of the Request for Proposals (RFP) and awarding of the projectized contract, and slow procurement of equipment and vehicles for the institutional contractor.

### 6.2.3 *The Institutional Contract*

The projectized portion of FPHP is implemented by The Futures Group International, the International Science and Technology Institute, and the Center for Communication Programs. Despite a contract signing 18 months after approval of the project paper, managerial barriers in the transition from GSMP to GSMF, and difficulties in accessing local currency funds for IEC, PHRLs, and NGOs, the contractor has managed its assigned Scope of Work with particular attention to skills transfer and sustainability. GSMF, IEC, and PHRL activities succeeded in institutionalizing improved capacity. Sustainability of the Foundation has been supported through the employment and extensive training of staff. Training has occurred both externally and on-site by long-term advisors and short-term technical assistance. Subcontracts for packaging, distribution, advertising, and research, plus management of return-to-project funds, indicate continuing capacity for essential social marketing activities.

Project implementation began quickly after the signing of the contract. Activities during the first two months following contract signing include the arrival of the long-term advisors, the set up of the project office, and the employment of senior Ghanaian staff members. The contractor used rented computers and vehicles while awaiting the eventual arrival of USAID procurements. Contractual arrangements with CME facilitated early administrative start-up. Continuing contractual relations with CME have institutionalized a capacity to support GSMF and similar activities beyond the FPHP end of project. First-year managerial activities included the incorporation of GSMF; the signing of memoranda of understanding with packagers, distributors, and advertising firms, plus strategy development activities; and fielding both the Consumer Baseline Survey and the Private Sector Providers Study. FPHP long-term advisors also spent substantial time on the development of USAID's population strategy and drafting the Project Implementation Document and the Project Paper for GHANAPA.

Managerial challenges encountered by GSMF social marketing included reconciliation of contraceptive stock accounts from the prior CSP with DANAFCO, an impasse over the packaging and distribution of Oral Rehydration Salts (ORS) by GSMF, a Deloitte-Touche audit of GSMP, and the status of GSMP equipment and vehicles. All of these issues were eventually resolved. For ORS, GSMF assumed the right to contract directly with the supplier, Danex, for manufacturing and nationwide distribution. The MOH terminated its contractual relationship with DANAFCO.

CCP is responsible for FPHP IEC activities. Prior to the institutional contract, CCP had undertaken successful IEC campaigns in three regions. Under FPHP, these activities were to include an additional four regions. An IEC assessment, external training for HEU and regional staff members, a management analysis of the HEU, renovation of HEU offices, management development workshops, and training in desk-top publishing served to improve both the competency and morale of health educators at central and regional levels. The primary constraint in this activity was accessing NPA-generated funds. Among activities abandoned due to lack of local currency funds were technical assistance visits to regions, research activities, and seminars. IEC campaigns were developed for each region but were initiated only in the Eastern and Western Regions. In the

Eastern Region, lack of funds caused the campaign to cease after the launch in all 15 districts. The campaign in the Western Region progressed even less. Given the success of prior campaigns in other regions and the documented constraint of method misinformation on the growth of family planning activities, these regional campaigns should be made a funding priority for the recently released third tranche funds.

ISTI was responsible for development of PHRLs and improvements in MOH clinical laboratories. These activities included the assessment of facilities and personnel, management of construction and renovation activities, extensive procurement, continuing on-site and external training of counterparts, and the management of numerous training activities for laboratory personnel. As noted in Chapter 5, PHRL activities as well as clinical laboratory training were constrained by access to NPA-generated funds. The ISTI role also included NGO development and employer-based services; the latter was initiated only shortly before this evaluation and was not reviewed.

#### *6.2.4 American College of Nurse Midwives*

ACNM provides technical assistance to both NTBA and the GRMA. Its cooperative agreement expires November 1995 and no extension or renewal is planned. Under the CSP, NTBA was organized as a pilot project administered under the Research and Evaluation Unit of the MOH. Integration of the NTBA into MOH MCH/FP, plus decisions by the FPHP TAC to allocate local currency funds to support continued NTBA training, indicates MOH commitment to the use of TBAs in promoting safe motherhood, and to a lesser extent, in resupplying short-term modern methods of contraception.

Similarly, GRMA was a nascent organization dependent on USAID-provided TA under CSP. At the conclusion of FPHP, GRMA is a self-directed organization characterized by extensive and enthusiastic volunteer participation. Regionalization of the GRMA supervisory activities emphasizes the maintenance of quality of care standards. Reliance on external TA has diminished. Sustainability of GRMA is being attempted through a GHANAPA grant that exceeds the annual funding levels available under the FPHP cooperative agreement.

### **6.3 FPHP Non-Project Assistance and Return-to-Project Funds**

#### *6.3.1 NPA Tranche Funds*

Delayed release of tranche funds impeded timely implementation of FPHP. Recent release of the third tranche—nearly half of the local currency funds generated by the three tranches—provides the TAC with an opportunity to review FPHP objectives and apply these funds to achieve outstanding FPHP objectives. IEC and PHRL activities are particularly in need of immediate support.

TABLE 3

<b>MFEP DISBURSEMENTS OF NPA FUNDS THROUGH MARCH 21, 1995</b>		
Millions of Cedis		Percent of Disbursements
MOH*	5,040	75%
GSS	245	4%
NPC	340	5%
GNFPP	26	0%
FPHP/Secretariat	65	1%
Population Impact Program (Univ. of Ghana at Legon)	70	1%
USAID Trust Fund	955	14%
G. Dankwa Accounts	7	0%
Total Disbursed	6,748	100%

Source: Gyechie Dankwa & Co., Chartered Accts.

\*MOH disbursement includes some NGO funding, e.g., for GRMA construction.

FPHP NPA consisted of three tranches: a US\$3 million tranche followed by two tranches of US\$5 million each. Funds were deposited in a Bank of Ghana account at Citibank, New York, and converted into cedi funds designated for expenditures by FPHP implementing agencies. These funds were treated as extra-budgetary allocations.

Delays in the release of tranche funds affected the production of IEC materials; the conduct of IEC campaigns; construction, renovation, and commodity supply of surgical theaters to be used for VSC procedures; TBA training; IEC materials for CBDs; and the funding of expanded MOH outreach activities. Delays were due to multiple problems. The first involved interpretation of substantive conditionalities, activities that were required prior to tranche release. Other delays were procedural. GOG democratization during the course of FPHP meant that decisions made by committee decree at the onset of FPHP required lengthy parliamentary processes later in FPHP. Of the 1994 MOH FPHP budget, only 42 percent was disbursed due to tranche release delays (see Table 4).

TABLE 4

MOH DISBURSEMENT OF NPA FUNDS AS OF MARCH 31, 1995 (MILLIONS OF CEDIS)					
	1993*	1994	1995	Total	% of 1994 and 1995
PHRL		654	94	748	32%
AIDS		41	52	92	4%
MCH/FP/TBA		624	194	818	35%
HEU		282	50	332	14%
Nutrition		9	0	9	0%
Epidemiology		18	0	18	1%
Guinea Worm		134	0	134	6%
External Aid Coordination/Program Planning, Monitoring, and Evaluation		177	15	192	8%
Pharmacy Board		10	3	12	1%
Manpower		0	0	0	0%
TOTAL	516	1,948	408	2,356	100%
Budgeted	848	4,623	4,699		
% of Budgeted Expended	61%	42%	9%		
Total Transferred from MFEP to MOH				5,040	
Disbursed by MOH 1993–1995, 1st Quarter				2,872	
Percent of MFEP Transfers to MOH Disbursed by MOH					47%

\* 1993 expenditure breakdown unobtainable during evaluation

Because of these delays and the recent arrival of the third tranche, much of the NPA-generated local currency funds remain unexpended. Five months into 1995, only nine percent of the 1995 MOH FPHP budget has been disbursed. The MOH intends to use approximately 30 percent of the existing balance to refund FPHP-related expenditures incurred during the period in which the fund was depleted due to tranche delays. Tables 3 and 4 denote disbursements— not expenditures. As of the February 1995 TAC meeting, no expenditure returns had been received for 1994 funds disbursed. The MOH external aid coordinator reports that this remains a problem with only a few MOH units having submitted expenditure returns.

### 6.3.2 MOH Fund Release Constraints

Constraints to the access of NPA-generated local currency funds were not limited to tranche delays. Once funds are disbursed from the MFEP to the MOH FPHP account, MOH units must still obtain normal expenditure approval. This approval at times has been delayed or refused by officers unfamiliar with or not in agreement with the objectives of FPHP. Respondents suggest these problems arose from a lack of capacity by unit heads to competently prepare the request for expenditures and persuasively argue their cases. USAID and the MOH external aid coordinator

should monitor this process to assure timely expenditure of funds during the remaining FPHP length of project.

### 6.3.3 Return-to-Project Funds

FPHP includes provisions for a return on contraceptive sales from both the public and private sector. The GSMF return-to-project fund provides for approximately 15 percent of the non-commodity 1994 recurrent expenditures of GSMF and is expected to grow to 54 percent by the year 2000. The GSMF return-to-project funds total nearly 400 million cedis through April 1995.

TABLE 5

MOH RTP <sup>1</sup> FUNDS, NEW PRICES, BY METHOD, BY ADMINISTRATIVE LEVEL							
	1994 (000s)	Price Cedis	Total Cedis	Subdist. 50%	Distric t 10%	Region 10%	Central 30%
millions of cedis							
OCs	672	80	54	27	5	5	16
VFT	1,812	25	45	23	5	5	14
Condom	4,987	15	75	37	7	7	22
IUD	15	200	3	2	.5	.5	1
Injectable s	154	120	19	9	2	2	6
Total			196	98	20	20	59

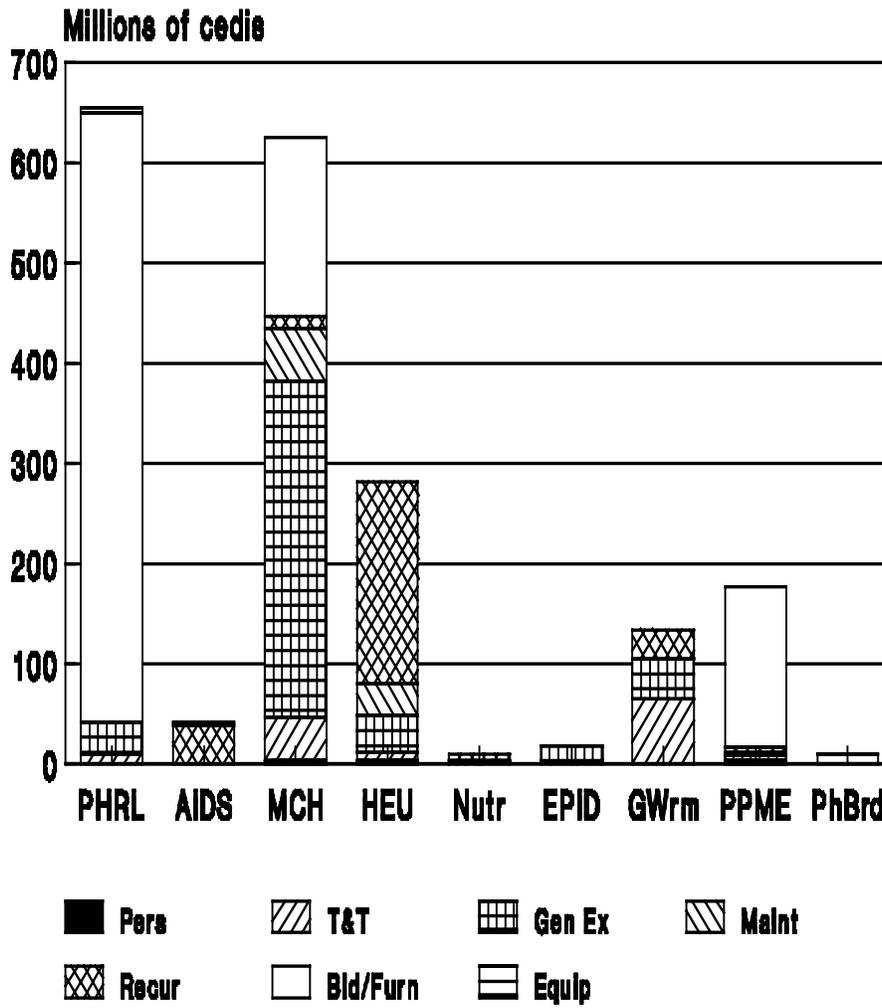
The MOH USAID return-to-project fund has a current balance of 59 million cedis. Only three regions<sup>1</sup> have made deposits during the last year. If properly managed, the MOH return-to-project fund will yield 60 million cedis annually.<sup>2</sup> Recent changes include new public sector pricing, based on the findings of the NPC-sponsored study, "Contraceptive Pricing and Sustainability in Ghana," and a revised allocation that leaves a greater portion at the subdistrict level. The allocation now matches the UNFPA required allocation, thereby simplifying accounting. While the return-to-project fund was intended to support GOG involvement in contraceptive procurement, if regulations permit, the funds would be better used to procure consumables to support VSC procedures and expand MCH/FP outreach activities.

1 Central, Western, and Brong Ahafo

2 Assuming new prices and new distribution by administrative level.

GRAPH 6

# MOH FPHP 1994 by Expenditure Type



## **6.4 MIS and Contraceptive Logistics**

### *6.4.1 Management Information Systems*

FPHP includes MIS activities for both GSMF and the public sector. At GSMF an MIS officer was employed and he assisted in the design and implementation of computerized systems to monitor contraceptive stock movements. He has since left GSMF employment. Two contracts have been let for the programming of compatible database applications to be installed at GSMF, the packager, and each of the distributors. This is not yet operational. Frankly speaking, paper reporting from the distributors and a simple spreadsheet at GSMF would be sufficient and sustainable.

For the MOH, FPHP has not provided much MIS technical assistance. PPME agreed to the placement of a Michigan Fellow; it was subsequently decided that this would not contribute to long-term sustainability. Family planning service statistics are not at PPME; rather they arrive and are processed at the MCH/FP unit. For the remainder of FPHP, a short-term pragmatic option would be to provide TA to the MCH/FP unit and, through collaboration with PPME, demonstrate how service statistics can be used at decentralized levels to improve supervision and management.

MCH/FP has a family planning data collection system that has become increasingly reliable over the last 10 years. It predicted public sector prevalence reported by the GDHS within two-tenths of a percent. Regional Health Management Teams (RHMTs) use the CYP and prevalence data in tables and charts included in their annual reports. At the central level, the earlier computerized version of this system has deteriorated during the course of FPHP to a pencil and paper operation. Over time, the single spreadsheet outgrew the memory capacity of the aging computer available to secretaries in the MCH/FP unit. Minimal assistance from FPHP could transfer these files to the newer computers and return the system to a sustainable computerized operation. Also, FPHP currently has no training database. For example, it is not possible to identify the location of providers trained by JHPIEGO and quantify the impact of the training on family planning services at their sites. This is presently being addressed, as a new database and projection model, PROTRAIN, is being adapted for use in Ghana.

### *6.4.2 Private Sector Contraceptive Logistics*

The managerial shift from a single packager/distributor under GSMP to multiple distributors under GSMF has increased market penetration. October 1992 data indicated stock-outs (that is, ruptures in supply) of socially marketed brands in more than 60 percent of pharmacies and chemical sellers in Greater Accra. The September 1994 retail audit reports 80-90 percent penetration of established GSMF brands in six regions. The same managerial shift has also inflated the quantity of contraceptives at central level warehouses. A system based on multiple distributors requires that each distributor's central warehouse maintain an adequate supply. Current stock inventories aggregated from central warehouses divided by either 1994 annual or 1995 first quarter sales show that multiple years of condom stocks are at the central level. The 21-month pipeline design suggests a nine-month supply at the central level. Since recent condom shipments have been canceled, much of this stock is already aging beyond appropriate usage dates.

Expired or nearly expired condoms<sup>3</sup> (both Panther and Protector) were found frequently in pharmacies and chemical sellers in multiple regions, as well as at central warehouses. Protector condoms manufactured in 1990 were found in closed cupboards at one distributor warehouse. The 1990 manufactured condoms must be removed from circulation and greater attention given to streamlining the pipeline. Extensive research concludes that five-year-old condoms in hot, humid climates are likely to have high breakage rates, putting customers at risk of STD infection and working against condom promotion efforts in both the public and private sector. Although it is often difficult to recall and destroy expired product, more has been invested in the social market program than in a few shipments of condoms. It is better to burn expired product and save the program reputation.

GSMF is aware of the situation and plans the following interventions: (1) a GSMF driver will retrieve condoms from identified outlets; (2) the Chemical Sellers Association will advise its members to remove 1990 condoms from the shelf and request replacement with new condoms; (3) MSRI, during an already anticipated distribution of promotional material, will identify the location of 1990 condoms; (4) future retail audits will collect information on manufacture dates; (5) FPLM will be requested to provide in-country contraceptive logistics training for GSMF staff, USAID staff, and distributor staff. Given the likely delays in organizing an in-country contraceptive logistics course, USAID and GSMF staffs should attend an upcoming FPLM course in Washington, D.C., in addition to organizing the in-country course.

#### *6.4.3 Public Sector Contraceptive Logistics*

The MOH "come and get" method of contraceptive distribution is an integral element of FP service delivery supervision. Each level collects contraceptives as it submits a periodic report. The report calculates required contraceptive quantities, return-to-project submissions, and CYP. The earlier 31 months pipeline has been reduced to 21 months. The Situation Analysis reports availability of the combined pill and injectables at 90-95 percent of MOH facilities. Lesser availability of IUDs and progestin-only pills (about 50 percent each) was likely a reflection of the training situation in 1993. Anecdotal information from site visits and respondents suggest JHPIEGO training is resolving this problem.

### **6.5 Conclusions**

Delayed release of tranche funds impeded timely implementation of FPHP. Recent release of the third tranche—nearly half of the local currency funds generated by the combined tranches—provides the TAC with an opportunity to review FPHP objectives and fund remaining activities, particularly IEC and PHRL activities.

USAID/HPN has managed FPHP with increasing emphasis on the involvement of contractors, CAs, the GOG, and MOH. Funds for buy-ins and cooperative agreements have been expended in a timely fashion. Early projectized implementation was delayed by the belated addition of an HIV/AIDs component, development of the RFP, and awarding the institutionalized contract.

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<sup>3</sup> Manufacture dates of October, November, and December 1990.

The projectized portion of FPHP, despite a contract signing 18 months after approval of the Project Paper, managerial barriers in the transition from GSMP to GSMF, and difficulties in accessing local currency funds, has managed its Scope of Work with particular attention to skills transfer and sustainability. GSMF, IEC, and PHRL activities succeeded in institutionalizing improved capacity.

Return-to-project funds provide for approximately 15 percent of the non-commodity 1994 recurrent expenditures of GSMF. The MOH USAID return-to-project fund has an April 1995 balance of 59 million cedis. Only three regions have made deposits during the last year. If properly managed the MOH return-to-project fund will yield 60 million cedis annually.

The managerial shift from a single packager/distributor under GSMP to multiple distributors under GSMF has increased penetration. It has also inflated the quantity of contraceptives at central level warehouses. Nearly expired condoms are in circulation and are found at central warehouses and should be withdrawn.

## **6.6 Recommendations**

17. TAC meetings should facilitate GOG ownership of FPHP. The TAC should be the mechanism through which GOG representatives design, monitor, and review FPHP implementation, with budgeting as a component of the larger activity.
18. Within the MOH, officers with responsibility for approving expenditures and unit heads with implementation responsibilities should work together to eliminate expenditure approval delays.
19. The MOH should have greater participation in the selection and timing of short-term technical assistance visits. Provision of resumes and better consultation regarding timing of visits would help accomplish this.
20. MOH return-to-project funds should be used to procure consumables for VSC procedures.
21. The institutional contractor should provide TA to the MCH/FP unit and, through collaboration with PPME, demonstrate how service statistics can be used at decentralized levels to improve self-assessment, supervision, and management. These data report essential GHANAPA conditionalities.

## **7 CONCLUSIONS**

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### **7.1 Introduction**

On balance much progress was made in the fields of MCH/FP and HIV/AIDS in Ghana through the support of the FPHP program. Contraceptive knowledge and use increased, choice and availability of methods has expanded, and there have been changes made in operational policies that will improve access and quality of care.

Overall, the program was managed well with most components making reasonable strides to achieve their targeted goals. Implementation was participatory and fostered multi-sectoral cooperation. Management capacity shows evidence of improvement at both the central and regional levels. Finally, there is a growing base of survey data that will be important in monitoring changes in the program over time.

The evaluation brought to light several areas of concern to be addressed during the remainder of this program and during the follow-on GHANAPA program. In the short term, the MOH is under pressure to spend the remainder of the NPA project funds that were released under the delayed third tranche. This presents an opportunity to implement some of the activities planned earlier and suspended.

For the longer term, the NPC must become more proactive in strengthening its role as a technical coordinating body.

Social marketing condom distribution has stagnated in the past year. Also, there are too many old and nearly expired condoms present in Ghana. Family planning outreach activities in rural areas are weak and have limited the availability of condoms and oral contraceptives to this share of the population.

Finally, the development and renovation of the laboratory system implies costs for long-term maintenance and consumable materials and the need for high caliber technical personnel. GOG support for these elements should be monitored to ensure that the laboratories function at a high standard.

The remainder of this chapter provides a summary of cross-cutting issues that emerged during the FPHP evaluation.

### **7.2 Ownership of the Ghana Program**

Increasingly, respondents within MOH and MFEP claim ownership of the MCH/FP program, and to a lesser extent, the HIV/AIDS program. There is a growing sense of the need to develop a comprehensive family planning and health care program. Once in place as a coherent whole, the MOH can seek government and multi-donor support rather than accept individual projects offered by external agencies. This process is under way and will probably become stronger as planning capacities in MOH continue to grow. The MOH is more actively involved in project design and takes the opportunity to ensure that projects address Ministry priorities.

### **7.3 Coordinating Committees and Advisory Groups**

The MOH, MFEP, and NPC did not optimize the value or utility of coordinating committees and advisory groups during the term of FPHP. The appropriate use of such groups could contribute much to the appreciation of a program like FPHP or GHANAPA as a tool to achieve local goals. Rather than spend inordinate amounts of time reviewing budgets, these groups should focus on questions of technical implementation and policy. The goal is to focus on programmatic issues and understand how the discrete activities undertaken contribute to the achievement of a coordinated and comprehensive program.

### **7.4 Non-Project Assistance**

Fulfillment of the NPA conditionalities was instrumental in promoting significant policy changes in Ghana. It was also important as a means to foster intra-ministerial dialogue within the MOH, as program managers were forced to justify and defend their programs particularly during 1994 when disbursements were delayed. Inter-sectoral linkages across program components were strengthened and institutionalized. At the same time, there was inordinate attention given to meeting the CPs without a full understanding of why they were present at all, i.e., as a means to contribute to the overall development and institutionalization of population, family planning, and HIV/AIDS programs in Ghana.

Many respondents expressed grave concern with the accessibility of NPA funds for their programs under the new arrangements introduced in GHANAPA. They are worried that without designation of NPA funds as extrabudgetary, it will be difficult to claim program support, particularly at decentralized levels. At the same time, it is program action at the lower levels that will drive the MOH to achieve its annual CYP targets. It will be very important to inform regions and districts about annual benchmarks and provide the support they will need in order to reach them.

As the central MOH moves from being an implementing organization to a technical, policy-making, and support organization, it must continue to increase support to the lower levels of the system that will be assuming proportionately greater responsibility for the delivery of health care services.

### **7.5 Decentralization**

The role of the MOH will be changing during the term of GHANAPA, as current programs to decentralize MOH activities accelerate. This will require major shifts in the type of work carried out at headquarters. It should not be assumed that these shifts will be made easily, nor that staff members currently possess the skills needed to carry out their new roles effectively. Implementation of GHANAPA presents an opportunity to develop or strengthen capacity in short- and medium-term planning, information systems, management, finance, standard-setting, etc. At the same time, program implementors should be alert for opportunities to strengthen capacity at region and district levels.

## **7.6 Improved Management Capacity**

Observers both within and outside the MOH cited the strengthened management capacity that has developed in large measure due to the requirements of FPHP. Staff skills in work planning and budgeting are stronger, and staff confidence has grown; this is evident at headquarters as well as at the regional level. The MCH health information system produces current data that are used routinely for monitoring and program planning. Strategic planning and coordination of programs and information campaigns are admirable. Management of subcontracts is also well done.

## **7.7 Quality Assurance**

Quality assurance has emerged as a topic of concern to service providers and policy-makers alike. While there is still far to go in the achievement of uniformly high-quality services through the Ghana health system, increasing attention is being paid to questions of infection control, provider bias, and inappropriate application of client precautions.

## **7.8 Integrated Family Planning and AIDS Activities**

It was not anticipated in the FPHP design that integration of family planning and AIDS activities would occur to the extent that it has. Coordinated IEC campaigns were planned, the social marketing component adopted both contraceptive and AIDS prevention marketing strategies, and policy changes occurred within the MOH to focus greater attention on HIV/AIDS. An important addition of GHANAPA is the new emphasis being placed on STD diagnosis and treatment. This is expected to both improve quality of contraceptive services and limit AIDS susceptibility. Work remains to be done on changing provider attitudes regarding the appropriateness of discussing HIV/AIDS with their clients. The study of provider attitudes showed that while nearly all clients would like to speak with a health care provider about AIDS, only about half of the providers feel comfortable discussing the topic with clients.

## **7.9 Program Balance**

Ghana's family planning program blends social marketing, static clinic facilities, and outreach activities. The balance achieved among these service delivery modes will have implications for the method mix of the program. To the extent that services are extended to the majority of the rural population, it is likely that the program will continue to show demand for short-term methods that are easily distributed at the community level.

## **7.10 Sustainability**

While financial sustainability under FPHP experienced mixed results, it is important not to lose sight of the program and institutional development that occurred. Ongoing efforts to define contraception as a socially accepted norm are likely to have the effect of generating demand for a large family planning program. Consideration of costs are certainly important but not to the point of jeopardizing the momentum of program growth. A balance must be struck between the demands of

sustainability and the desire to have an extensive program of rural access, typically a high cost mode of distribution.

### **7.11 Information Systems and Survey Data**

An important resource is being developed in the form of survey data and information systems. Ghana now has available a set of good quality data to use in monitoring program growth and development and in identifying targets of intervention.

### **7.12 Case Studies**

The team believes that the experience of Ghana through the FPHP program offers lessons of interest to the wider family planning, AIDS, and USAID community. Specifically, three topics merit further documentation and study:

- The evolution of social marketing of contraceptives
- The implementation of Non-project Assistance
- The integration of family planning and HIV/AIDS programs

## **APPENDICES**

## APPENDIX 1

PIO/T-641-0118-3-40024  
Attachment B

### Team Scope of Work

#### Mid-term Evaluation of the Ghana Family Planning and Health Program (FPHP)

##### I. Background

The Family Planning and Health Program (FPHP) was designed in 1991 to assist Ghana to achieve its fertility goals and address the increasing HIV/AIDS problem through an expanded family planning and HIV/AIDS control effort in Ghana. Despite having a population policy in place for twenty years, fertility and population growth rates had not significantly slowed. A lack of concentrated effort on the part of government and general economic collapse contributed to this situation. Recognizing the negative impact of rapid population growth, the Government of Ghana decided to renew its commitment to population and family planning efforts.

The goal of the FPHP is to assist the GOG to lower its fertility rate through family planning and maternal and child health interventions. The program purpose is to increase the use of and demand for family planning through expanding the public and private sector capacity for providing family planning, maternal child health services and supplies, and to increase the effectiveness of HIV/AIDS prevention and control activities. Because a contributing determinant of demand for family planning services is the rate of infant and child mortality, program efforts include expanding the distribution of oral rehydration salts and anti-malarial medication.

The \$35 million program was signed on April 25, 1991, and will terminate on March 31, 1996. It consists of a \$13.0 million Non-Project Assistance (NPA) cash grant to the government, a \$15.5 million Bilateral Grant, and \$6.5 OYB transfer for the provision of contraceptive commodities. The FPHP is implemented in the public sector by the Ministry of Finance and Economic Planning (MFEP), the National Population Council (NPC), the Population Impact Program (PIP) at the University of Ghana/Legon, the Noguchi Biomedical Research Institute, and the Ministry of Health (MOH). Within the MOH, the FPHP is guided by the External AID Coordination Unit, Maternal and Child Health/Family Planning (MCH/FP), National AIDS Control Programme (NACP), Human Resources Development Division (HRDD), Health Education, Health Research and National Traditional Birth Attendant (NTBA) units of the MOH are directly involved. Non-Governmental Organizations including the Ghana Social Marketing Foundation (GSMF), Ghana Registered Midwives Association (GRMA), and smaller NGOs also receive assistance and participate.

Technical assistance is provided by institutional contracts with the Futures Group (with subcontracts with ISTI and Johns Hopkind University) and the American College of Nurse Midwives, and buy-ins or cooperative agreement add-ons to the Association of Voluntary Surgical Contraception (AVSC), The Options Project, Johns Hopkins University/ Population Communication Services, Family Health International, and Macro Systems. Additional external technical assistance is provided by other centrally funded USAID/Washington projects.

In 1992 the Ghana Family Planning and Health Program was amended to include authority and resources for HIV/AIDS assistance. The strategy for this assistance has three elements: (1) to provide assistance in information, education and communication (IEC) activities directed at both improving knowledge and changing behavior; (2) to reinforce laboratory infrastructure and improve surveillance of the HIV/AIDS epidemic; and (3) to further expand the distribution of condoms.

#### A. Constraints Addressed by FPHP

##### Family Planning Activities:

###### Management

- *falling share of government expenditures for health, most of which is programmed for curative care and administration;*

###### Sustainability

- *the need for stronger public support in favor of family planning activities from doctors, other medical leaders, local authority figures and opinion leaders;*
- *the need to begin building a commercial contraceptive market which will one day be capable of functioning without donor support;*

###### Demand

- *the need to translate latent demand into use;*
- *the importance of shifting the method mix toward longer-term methods in order to achieve the desired slowing of the population growth rate;*

###### Supply

- *the need to alter the regulatory situation to reclassify contraceptive commodities, anti-malarials and ORS to ensure wider availability;*
- *the need to improve MOH handling of contraceptive commodities in order to reduce stockouts and loss of supplies;*
- *the need to improve availability of contraceptive products (particularly non-clinical methods), ORS and anti-malarials by expanding the network of distributors;*

##### AIDS Activities:

- *the need to engage top level Ghanaian decision makers in dialogue concerning HIV in relationship to other socio-economic issues besides health;*
- *the need for sufficient data on the dimensions of the epidemic to use as a tool in raising awareness of the dimensions of the problems and in acquiring support from the government and the public for AIDS activities'*

- *the need to stimulate a multi-sectoral response to tackling the AIDS epidemic and concurrently to raise the profile of the NACP as a coordinating organ.*

#### **B. NPA Program Component**

The NPA conditionality was designed to address policy/institutional constraints to delivery of family planning and maternal and child health services. The conditionality agenda focuses on : (1) establishment and operation of the National Population Council, establishment of demographic goals, preparation and adoption of a National Population Policy Implementation Plan; and (2) regulatory reforms with respect to availability of drugs and contraceptives, price controls, and duties. The NPA dollar grant is matched by jointly-programmed local currency to support FPHP activities, which is administrated by a Technical Advisory Committee (TAC) consisting of the MFEP, MOH and USAID. Recurrent costs – for MOH family planning, health education, AIDS and child survival activities, NPC, PIP – and construction of reference laboratories, an IE&C center and AVSC faciities are funded by the NPA account.

#### **C. Project Assistance Component**

Project assistance addresses constraints to greater usage of contraceptives and service delivery by targeting both the public and private sectors. The basic elements of these two components are: (a) delivery of family planning services and social marketing of contraceptives, oral rehydration salts and chloroquine; (b) information, education and communication on family planning; and (c) training of family planning service providers. Project assistance supports technical assistance, vehicles, equipment, commodities and external training and travel geared toward improving the capability and increasing the capacity of health care providers in both the public and private sector to deliver contraceptives along with clinical services in family planning, maternal and child health and AIDS control.

For the AIDS Component, project assistance provides technical assistance in laboratory training, management, and IE&C to increase awareness and increase use of condoms. The project also provides equipment, vehicles and materials for the HIV/AIDS control program and laboratory unit of the MOH as well as condoms in conjunction with the family planning program.

#### **D. End of Project Status**

- **contraceptive prevalence for modern methods will have risen from 5% to 15% nationwide;**
- **the use of oral rehydration salts (ORS) per diarrheal episode will have increased from 33% to 50%;**
- **the use of proper anti-malarial treatment for febrile episodes will have increased from 25% to 35%;**

- AIDS knowledge, attitudes and practices among the general population will increase;
- a national reference laboratory framework will be established which is providing backup and quality assurance to zonal, regional and district laboratories; and
- an accurate system of HIV surveillance will be established.

## II. Objective

The objective of this mid-term evaluation of the Ghana Family Planning and Health Program is to assess the status of the project viz a viz its stated purpose and objectives, identify problems/constraints to meeting objectives and accomplishments, quantify the impact of the program to date against the EOPS indicators, and recommend any necessary changes in course of action for the remainder of the program. The team should also identify issues which need to be addressed during the transition period from the FPHP to the Ghana Population and AIDS Program (GHANAPA).

## III. Statement of Work

The team will conduct a mid-term evaluation of FPHP components and activities which will provide USAID/Ghana with an analysis of the current status of the program, identification and analysis of accomplishments/problems, assessment of institutional/management arrangements, and other issues that impact on program implementation, along with specific, prioritized and justified recommendations for improvement through the end of the program. The evaluation will contain, but not be limited to, the following issues for family planning and AIDS activities:

- *progress in attaining purpose-level objectives*
- *status of achieving policy and project benchmarks and their impact on the program;*
- *identification of constraints to achieving objectives,*
- *analysis of validity of initial program assumptions;*
- *effectiveness of project implementation arrangements;*
- *adequacy of benchmarks and indicators for assessing impact;*
- *recommended changes in indicator monitoring, if necessary;*
- *status of outputs;*
- *analysis of management of inputs;*
- *analysis of institutional performance and relationships in MOH and implementing agencies;*
- *adequacy of training provided to CBD agents, service providers, etc. and whether the impact of training is adequately assessed under current project monitoring and evaluation arrangements;*
- *the effectiveness of technical assistance provided to date – whether in terms of content, strategy, coordination, or timing– and recommendations on improvements.*

In addition to the above information, USAID/Ghana would like the team to address specific questions as follows:

- **The National Population Council (NPC) secretariat** - recommendations on how to ensure that the NPC is capable of managing its growing agenda, especially the coordination of all

population activities in Ghana, the database created by FPHP and the collection, integrity and analysis of data.

- **MOH Decentralization Process** - assessment of impact of decentralization on health system managers at regional and district levels and recommendation regarding effective oversight and supervision of health care managers.
- **Institution building** - how effective are contractors in transferring skills and technology as they work with counterparts within the MOH, NGOs and other local entities?
- **Social Marketing Program** - how effective and cost efficient are the marketing strategy, training, distribution and pricing policy and promotional activities? Is the market research agenda appropriate to the design and implementation of the social marketing activities? What is the support of key opinion leaders and the medical community for social marketing, and how could it be improved? Are the sales targets appropriate with respect to project inputs and the socio-economic situation and experience of social marketing in Ghana? What is the amount and use of local revenues generated by commodity sales?
- **FPHP institutional contractors' project management/institutional relationships** - Issues to be considered here are: (1) Coordination between FPHP institutional contractors and TA from centrally funded projects -- Are synergies being effectively captured? Are there duplications of effort? (2) FPHP institutional contractors' external relationships with GOG counterparts, local NGOs, other local entities, and USAID -- Assess their responsiveness in providing/sharing information? How well do they perform in meeting USAID reporting requirements? To what extent have they established effective relationships with counterparts?

The team will provide the Mission with recommendations for the last two years of the program.

**Documents to be reviewed:**

Project Paper for the Family Planning and Health Program  
Project Paper for the Ghana Population and AIDS Program  
Ghana Population Sector Strategy  
Trip reports from the Family Planning Logistics Management Project  
Trip report from 1993 MIS assessment  
Results of the 1993 Consumer Baseline Survey  
Preliminary report of the 1993 DHS  
Draft report from the 1993 Situation Analysis (if available)  
February 1994 report, *Strategies for Monitoring and Evaluation of the USAID/Ghana Family Planning Program*  
September 1994 in-depth analysis of service provider practices from the Situation Analysis data  
March 1994 report of a study done on STD treatment in the private sector  
September 1994 report on detailed analysis of data from the 1993 DHS  
Reports from FPHP, AVSC, GRMA, PPAG

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Trip reports from OPTIONS/RAPID TDYs

#### IV. Team Composition

The external evaluation team will be composed of four (4) individuals as follows: (1) family planning policy specialist, (2) family planning program specialist, (3) management specialist, and (4) AIDS program specialist. Team members will work with identified Ghanaian counterparts who have knowledge and background related to specific project components. USAID will ask the GOG to identify in-country resource persons and contacts for the evaluation team members. At least one member of the evaluation team would preferably be Ghanaian.

All team members must possess excellent written and oral communication skills and be completely familiar with WordPerfect word processing. The team will provide its own secretarial support. Specific qualifications for each of the team members will be as follows:

1. Family Planning Policy Specialist/Team Leader: This individual is the team leader and will be responsible for coordinating team members, establishing an evaluation schedule and ensuring that a draft document is presented to USAID. He/she will be responsible for analyzing the progress on the policy agenda of the program. The specialist should have a minimum of 10 years experience in a broad range of family planning program areas with particular emphasis on family planning policy in developing countries. Previous experience conducting evaluations of USAID family planning programs and serving as team leader is required. A graduate degree in population, health or health-related field is required and previous experience in leading similar teams is essential.
2. Family Planning Program Specialist: This individual will be responsible for working on the family planning service delivery and demand creation portion of the program in both the public and private sectors. A minimum of 5 years experience in a broad range of family planning program areas with particular emphasis on family planning service delivery in developing countries is required, as well as previous experience serving on USAID evaluation teams and a graduate degree in population, health or health-related field.
3. Management Specialist: This specialist will be responsible for analyzing the relationships of USAID/Ghana, USAID/Washington, contractors, the MOH, MFEP and other actors in the overall functioning and management of the program. He/she will also evaluate the logistics of commodities provided by the program through the MOH and the GSMF. This individual should have a graduate degree in administration, management or the social sciences with field research experience in developing countries, preferably Africa. Five years experience in developing and assessing public and private sector contraceptive commodity logistic and information systems is required.
4. AIDS Program Specialist: This individual will be responsible for evaluating the AIDS component of the program. Ten years experience in developing and assessing AIDS programs in developing countries, along with an extensive clinical background in a broad range of AIDS program elements (public policy; laboratory services; training; and

information, education and communication) is required. A graduate degree in public health, or other related field involved in AIDS activities is required.

## V. Reports and Deliverables

Upon arrival, the evaluation team will orally brief USAID/Ghana and others on the methodology to be used, timing and review process for the evaluation. USAID will make available all documents and information required by the team and brief the team on the project, purpose and objectives of the evaluation to ensure mutual understanding and status of host country participation in the evaluation and logistical arrangements. The team is required to keep USAID informed of any problems/unusual findings or other issues which may need greater clarification.

At the beginning of the in-country evaluation the project evaluation team and designated Ghanaian counterparts will meet to refine the terms of reference; define responsibilities for individual team members, review scopes of work; read project documents; develop evaluation tools where necessary; hold meetings about evaluation expectations under USAID leadership; and conduct team building exercises.

Prior to departure from Ghana, the evaluation team will orally debrief USAID and provide ten (10) copies of a draft report for comment by USAID. USAID will respond in writing to the team leader within two weeks of the team's departure from Ghana.

The evaluation team will produce a final report within two weeks of receiving written comments to the draft report from the Mission. Twenty (20) copies of the final report should be submitted to USAID/Ghana along with one diskette containing an electronic version of the report in WordPerfect 5.1 format.

In addition to an executive summary, the contents for the evaluation report should follow the structure outlined below:

**THE POLICY ENVIRONMENT**  
**SERVICE DELIVERY IN THE PUBLIC AND PRIVATE SECTOR**  
**SOCIAL MARKETING AND DELIVERY SYSTEMS IN THE PUBLIC AND PRIVATE SECTOR**  
**AVAILABILITY OF FAMILY PLANNING/MATERNAL AND CHILD HEALTH INFORMATION**  
**HIV/AIDS ACTIVITIES**  
**PROGRAM MANAGEMENT**

The following topics should be discussed under each of the above headings:

*Status*  
*Accomplishments*  
*Problems*  
*Findings and Conclusions*  
*Recommendations*

## **VI. Roles and Responsibilities**

The members of the team will be contracted by POPTECH which will be responsible to the Mission for the final product.

While in Ghana, the evaluation team leader will work under the general direction of the USAID Mission Director and will report to the Chief, HPN Office. The evaluation team will coordinate routine activities and briefings with the TAACS Advisor of the HPN Office and the Mission Monitoring and Evaluation Specialist.

Evaluation activities - interviews, briefings, other meetings and writing assignments - will be coordinated by the evaluation team leader. The team leader is responsible for keeping Mission staff apprised of progress on the evaluation, needs for Mission assistance over the course of the evaluation and any problems encountered by the evaluation team during its work.

The MOH will designate liaison staff with the task of working with the evaluation team and participating in periodic briefings on the progress of evaluation activities.

An evaluation committee will be formed and comprised of representatives of USAID - the Chief of the HPN office, the TAACS advisor, the Mission Monitoring and Evaluation Specialist - and representatives of the Ministry of Health. The committee will meet initially with the evaluation team to discuss the scope of work and a schedule of events for the evaluation. Mid-way through the evaluation, the committee will meet again to discuss progress of the evaluation and any questions or problems encountered during the evaluation. The evaluation team will present its findings to the committee during a final meeting at the end of the evaluation.

**Budget Assumptions:**

- 1) Four person team for 4.5 weeks each for a total of 132 person days. One week in Washington (3-4 days for team planning meeting before travel to Accra and 3-4 days at end of field travel for debriefing and editing.)
- 2) For budgeting purposes a high salary is used. POPTECH will find the best available consultants at the most reasonable cost.
- 3) Any unused funds will be decommitted and returned immediately to the Mission for future use.
- 4) Vehicle and driver will be provided by Mission.

## APPENDIX 2

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APPENDIX 3

**LIST OF PERSONS CONTACTED**

**USAID/Ghana**

Ms. Barbara Sandoval, Mission Director  
Mr. William Jeffers, Deputy Mission Director  
Mr. Charles Llewellyn, Health, Population and Nutrition Officer  
Dr. Pam Wolf, Technical Advisor on AIDS and Child Survival  
Dr. Benedicta Ababio, Deputy HPNO  
Mr. Lawrence Aduonum-Darko, Project Officer  
Ms. Joanna Y. Laryea, Project Officer

Office of Population, AID/Washington  
Carl Hemmer (telcon)

**Family Planning and Health Project**

Mr. Don Dickerson, Chief of Party  
Mr. Alex Banful, Executive Director, GSMF  
Mr. Frederick Lokko, Distribution Manager, GSMF  
Mr. Bill Glass, IEC Advisor  
Ms. Alice Lamptey, NGO Coordinator  
Ms. Joanne Hettrick, Laboratory Advisor  
Ms. Comfort Minor, Personnel and Consultancy Services Manager  
Mr. Kojo Lokko, Commercial, Long Term and Clinical Method Manager  
Ministry of Health

**Program Planning, Monitoring and Evaluation Division**

Dr. Asamoah-Baah, Director  
Dr. Awudu Tinorgah, External Aid Coordinator

**Maternal and Child Health Unit**

Dr. Henrietta Odoi-Agyarko, Director

**National AIDS Control Program**

Dr. Phyllis Antwi, Manager  
Dr. Assamoah Odei, Deputy Manager  
Ms. Evelyne Quaye, Counseling Coordinator

**Health Laboratories, Ministry of Health**

Dr. Alex Asamoah-Adu, Head  
Ms. Veronica Bekoe, Laboratory Specialist, Public Health Reference Laboratory

**Health Education Unit**

Ms. Mary Kotei, Head  
Mr. J. K. Ofori, Research and Evaluation Coordinator  
Mr. N. Z. Ibrahim, AIDS IEC Coordinator

**Ms. Eleann Sey, Health Education Officer**  
**Mr. Mark Asare, Campaign Coordinator**  
**Ms. Mariam Asare, Training Coordinator**  
**Mr. J.S. Elepe, Project Accountant**

**Information, Monitoring and Evaluation Division**  
**Dr. Menuwe M. Bekui, Head**

**Regional MOH Administration**  
**Dr. Docia Saka, District Director of Health Services, Ashanti**  
**Dr. N.A. Addo, Regional Health Administrator, Volta**  
**Dr. Tetteh, Regional Health Administrator, Upper West**  
**Dr. J.E. Taylor, OB/GYN Koforidua Regional Hospital, Eastern**

**Adabraka Polyclinic**  
**Ms. Alice Dogbe, Family Planning Nurse**  
**Ms. Helenmary Bainsong, MCH/FP Unit Nurse**

**Korle Bu Family Planning Clinic, Accra**  
**Ms. Florence Ashitey, Senior Nursing Officer**  
**Ms. Mercy Offei, Senior Nursing Officer**  
**Ms. Victoria Davis, Senior Nursing Officer**  
**Dr. J. O. Armah, OB/GYN consultant, AVSC Project Director**

**Central Region MOH Office, Cape Coast**  
**Dr. Sory, Regional Medical Officer**

**Eastern Region MOH Office, Koforidua**  
**Dr. Ken Sagoe, Senior Medical Officer**  
**Mr. Steven Ntow, Regional Health Education Officer**  
**Ms. Grace Yamoah, Acting Deputy Director, Nursing Services**

**Koforidua Regional Hospital**  
**Mr. Oyinka Dua, Hospital Administrator**  
**Dr. Nogbe Gameli, Family Planning Coordinator**  
**Mr. Buer, Chief Laboratory**  
**Mr. Thomas Nti, Microbiologist**  
**Sister Elizabeth Opare, Family Planning Clinic**

**Central Hospital Family Planning Unit, Cape Coast**  
**Ms. Elizabeth Koomson, Nursing Officer**  
**Ms. Matilda Halm-Brown, Nursing Officer**  
**Dr. Alfred Dzady, Obstetrician-Gynecologist**

**Winneba District Hospital**  
**Mr. K.A. Adzanoiikpe, Senior Lab Technician**  
**Mr. J.S. Padl, Senior Hospital Secretary**

Winnèba Sub-District MCH/FP Clinic  
Ms. Dorothy Abudey, Public Health Nurse  
Ms. Veronica Quaison, Family Planning Assistant

MCH/FP Clinic, Cape Coast  
Ms. Theresa Menciah, Nurse  
Ms. Doris Awuku, Senior Nursing Officer, Primary Health

MOH Health Center, Assesewa  
Dr. Amo Kouame, Medical Officer  
Ms. Grace Ahipo, Nurse, CBD supervisor

Ministry of Finance and Economic Planning  
Mr. Charles Abakah, Director, IERD  
Ms. Agnes Batsa  
Mr. Emmanuel Darko

National Population Council  
Dr. Fred Sai, Executive Director  
Ms. Esther Wa-Abewokin, Director of Policy, Research and Training

Population Impact Project, University of Ghana  
Prof. John Nabila, Director  
Prof. Andy Aryee, Associate Project Director  
Dr. E.O. Tawiah, Associate Project Director

Noguchi Memorial Research Institute  
Prof. Francis Nkrumah, Director  
Dr. N. K. Ayisi, Senior Research Fellow  
Dr. M. Osei-Kwasi, Research Fellow

World Bank  
Mr. Greg Hancock, Senior Operations Officer  
Dr. Shiyao Chao, Health Economist (telcon)  
Dr. Dave Radell (telcon)

United Nations Population Fund  
Mr. Teferai Seyoum, Country Director

The Futures Group International  
Dr. Charles Pill, Washington (telcon)  
Mr. Tennyson (Don) Levy, Washington (telcon)  
Dr. Dan Kress, The Futures Group, Washington (telcon)  
Dr. Naomi Rutenberg, OPTIONS Project, Washington (telcon)

INTRAH  
Dr. Manuel Pina, Regional Clinical Director

**JHPIEGO**

**Ms. Anita Ghosh, Baltimore, MD (telcon)**  
**Ms. Mary Dampson, Training Coordinator, Greater Accra**  
**Ms. Lynn Gaffiken, Director of Research and Evaluation**  
**Population Communication Services**  
**Ms. Lori Liskin, (telcon)**

**POPTech**

**Ms. Jane Cover (telcon)**

**American College of Nurse Midwives**

**Ms. Debbie Armbruster, Resident Advisor**

**Ghana Registered Midwives Association**

**Ms. Florence Quarcoopome, Director**

**Planned Parenthood Association of Ghana**

**Mr. E.K. Kwansa, Consultant**

**Mr. Jeff Adja Kitcher, Program Officer**

**Planned Parenthood Association of Ghana, Cape Coast**

**Mr. Yaw Osei Asibey, Director**

**Ms. Mary Araba Fosu, Assistant Programs Officer**

**Ms. Juliana Brown, Family Planning Nurse Officer**

**Planned Parenthood Association of Ghana, Kumasi**

**Mr. Boakye Yiadom, Regional Manager**

**Mrs. Helen Appiah, Field Supervisor**

**Mr. Redford Owusu-Banahene, Field Supervisor**

**Korle-Bu Midwifery School**

**Ms. Gladys Kankam, MOH/JHPIEGO Training Coordinator**

**Ghana Nurses and Midwives Council**

**Ms. Ruth Gyang, Executive Director**

**Association for Voluntary Surgical Contraception**

**Ms. Connie O'Connor, Africa Director**

**Ms. Joana Samarasinghe, Program Officer**

**Ms. Akua Ed Nighpense, Program Officer**

**Dr. Nick Kanlisi, Country Coordinator**

**Dr. John Djan, Consultant**

**Lintas**

**Ms. Norkor Duah, Client Service Director**

**Mr. Dan Kermah, Technical Specialist**

**Mr. Emmanuel Mwinilayuori, Technical Specialist**

**Mr. Jacob Obetsebi Lamprey, Managing Director**

**Marketing and Social Research International**  
**Mr. Seth Bonnie, Managing Director**

**Johnson Wax**  
**Mr. John Totoe, Marketing Consultant**  
**Ms. Francesca Opokie, Manager GSMF account**  
**Mr. Ladi Nylander, Managing Director**

**DAPEG**  
**Ms. Della Sorwah, GSMF Account Manager**  
**Ms. Gifty Ahadzi, GSMF Account Manager**  
**Ms. Francisca Afun, Managing Director**

**STARWIN**  
**Mr. Paul Lawrence Cudjoe, Marketing Director**

**DANAFCO**  
**Mr. J. K. Williams, Marketing Director**  
**Mr. E. A. Kissi, Executive Chairman**

**New Akraide Village**  
**Mr. Daniel Owusu, Habitat Program Coordinator**  
**Mr. Emmanuel Debrah, CBD agent**  
**Mrs. Margareth Bruku, CBD agent**  
**Mr. Alex Obeng, Secretary, Community Implementing Committee**  
**Mr. Antony Cobbin, District Coordinator for Habitat**

**Atimpoku Village**  
**Mrs. Regina Afaribea, CBD agent**  
**Nana Budu Akoma III, Chief**  
**Nana J.A. Bright, Community leader**  
**Mr. Y.K. Gyamerah, Linguist**  
**Mr. J. K. Okantan, Linguist**

**Asugyaman District**  
**Mr. E.K. Ogori, Acting Coordinator Director**

**Central Region Administration**  
**Mr. L.K. Bayuoh, Administrative Officer**

**Peace Chemical Store, Atimpoku**  
**Mr. and Mrs. Joseph Manu**

**Felio Enterprise Chemical Store, Atimpoku**  
**Mr. F. Osei.**

**YMCA Kofrudua**  
**Ms. Nancy Mensah, CBD agent**

Plan International, Assesewa  
Ms. Elizabeth Pintu, Coordinator  
Mr. Robinson Tettey, Deputy Coordinator  
Ms. Vida Mono, CBD Agent  
Ms. Eunice Odonkor, CBD Agent  
Ms. Felicia Yemo, CBD Agent  
Ms. Beatrice Tetey, CBD Agent

Bethel Maternity, Winneba  
Ms. Jane Ekyem, Assistant

Pat's Maternity Home, Koforidua  
Ms. Kathlyn Ababio, Regional Chairman GRMA

Baby Pearl Maternity Home, Kumasi  
Ms. Jessie Adu-Myalco, Regional Chairman GRMA

Ashanti Region MOH Office, Kumasi  
Dr. George Amofu, Director, Regional Medical Services  
Mr. Fusu Munufie, Administrative Assistant MCH/FP  
Mr. Abbey Thomas, Regional Health Education Officer

Komfo Anokye Teaching Hospital, Kumasi  
Mr. Steven Nti, Chief Technologist  
Mr. Charles Owusu-Afrayie, Laboratory Technician  
Prof. A. P. Asafo-Agyei, Medical Administrator  
Mr. Albert Asiedu-Ofei, Principal Hospital Administrator  
Mrs. Diana Ofori-Awuah, Head Nurse, Family Planning Clinic  
Mrs. Victoria Minyila, Nurse, Family Planning Clinic  
Dr. John O. Djan, AVSC Coordinator, OB/GYN Department

Atwina District Health Center  
Mrs. Margerit O-Offei, Chief Nurse  
Mrs. Juliana Adu, Midwife  
Mrs. Wilhelmina Hesse, Community health nurse  
Mrs. Comfort Adjei, Community health nurse  
Mrs. Juliana Mensah, Community health nurse  
Mrs. Anna Ofori, Community health nurse  
Mrs. Christiana Yeboah, Community health nurse

Brong Ahafo Region MOH Office, Sunyani  
Dr. Nii Ayite Coleman, Regional Director Health Services  
Mr. Theodora Okyeri, Regional Health Education Officer

Mr. Abdul Wahab Sheriff, Chairman of the youth wing of the muslim community, Kumasi

Mrs. Agnes Obeng, Coordinator for CBD program, 31st December Movement, Kumasi

**Sunyani**

**Mr. Annan Charles, Chemical Store Sarpong**  
**Mr. Adday-Kyeruneh, Appi Boah Pharmacy**  
**Ms. Maria Amankwah, Onyame Chemical Store**  
**Mr. Samuel Nimaco, Nipa Chemical store**

**Konongo**

**Daasebre Osei-Bonsu, Chemical seller**  
**M. K. Ospusu, Chemical seller**

**Nkawkaw**

**Ms. Mercy Wiafe, Chemical seller**

**May Day Rural Project, Greater Accra District**

**Dr. Laryea Emmanuel, Executive Director**  
**Mr. E.R.A. Botuyway, Deputy Director**  
**Ms. Josephine Agbo, Project Coordinator**  
**Dr. Honore Aduayi-Akue, Coordinator, Entreaide Medicale Internationale**

**May Day Rural Project, Onyansanya Village**

**Mr. Joseph Azu, Project assistant, zone 1**  
**Mr. George Agbeyaka, Project assistant, zone 6**  
**Mr. Maxwell Oblie, Project assistant, zone 5**  
**Mr. Mahama Cheriff, Project assistant, zone 3**  
**Mr. David Appoe, Project assistant, zone 4**  
**Mr. James Nti, Project assistant, zone 11**  
**Mr. William Mfarfo, Project assistant, zone 9**  
**Mr. Moses Wodopey, CBD agent, zone 3**  
**Mr. Emmanuel Otuley, CBD agent, zone 11**  
**Mrs. Sarah Oblie, CBD agent, zone 1**  
**Mrs. Nancy Adegbe, CBD agent, zone 4**  
**Mr. Ahmed Abley, CBD agent, zone 11**  
**Mr. P. N. Amatey, CBD agent, zone 5**  
**Mrs. Nancy Nebleg, CBD agent, zone 9**  
**Mr. Jonas Otuley, CBD agent, zone 1**  
**Mr. Daniel Allatey, CBD agent, zone 4**  
**Mr. Evans Adom, CBD agent, zone 6**  
**Mrs. Beatrice Odoi, CBD agent, zone 6**  
**Mr. A. Ansah, Project assistant, zone 7**  
**Mrs. Vincentia Torkomo, Nurse, Onyansanya clinic**

**APPENDIX 4**

<b>END OF PROJECT STATUS INDICATORS: FPHP</b>	
<b>Increase modern CPR from 5.1% to 15%</b>	<b>GDHS showed modern CPR of 10.1%; project likely to reach goal.</b>
<b>Increase use of ORS per diarrheal episode in under fives from 33% to 50%</b>	<b>GDHS showed 48% of women had ever used ORS packets; 42% had used ORS or recommended home fluids for episodes 2 weeks prior to survey</b>
<b>Increase proper anti-malarial treatment per febrile event from 25% to 30%</b>	<b>Activities related to this purpose were eliminated from the project</b>
<b>Index of safe AIDS knowledge, attitudes and practices increased among general population</b>	<b>GDHS indicates 97% men and 95% women are aware of AIDS;</b>
<b>National lab network in place providing efficient and accurate diagnostic analysis, and generating surveillance data</b>	<b>PHRL construction completed, Work advanced in 2 zonal labs; Advanced course for 39 lab managers held; regional and district training continuing; report forms complete and implementation begun in all regions</b>
<b>HIS in place to provide accurate and regular HIV/AIDS monitoring data</b>	<b>System design completed; 1994 sero-surveillance report shows prevalence at 2-4% among pregnant women</b>
<b>Threefold increase in condom use from 0.9 to 2.7 million</b>	<b>9.4 million condoms sold 1994, below target</b>
<b>15% decrease in sexual partners (from 1.9 to 1.6)</b>	<b>1993 CBS reports mean number of sexual partners is 1.56</b>
<b>At least 10 NGOs actively involved in providing information and education to target groups</b>	<b>18 NGOs receiving training and materials and functions, target exceeded</b>

APPENDIX 5

INDICATORS OF THE POLICY ENVIRONMENT	
Existence of policy development plan	Revised National Population Policy Action Plan
Number of appropriately disseminated policy analyses	"Revised Population Policy"; FP pricing study; Provider bias study
Number of awareness-raising events targeted to leaders	4 workshops held in July 1994 (PIP); Contraceptive Technology Update workshop
Strategic plan to expand family planning program	Population policy action plans; draft guidelines; intersectoral cooperation; draft MOH integrated workplan
Integration of demographic data in development plans	High population growth cited as negative factor in GOG "Country Strategy Note"; Vision 2020; sector plans
Number of statements by leaders in support of FP	2 statements by President reported; 108 POP/FP articles published 8/94-4/95
Formal population policy	1989 policy revised 1994
National FP coordination	Responsibility of NPC; not fully operational
Level of FP program within government administration	FP in MOH; NPC in Office of the President
Levels of import duties and other taxes	Customs duties on chloroquine, contraceptives, ORS removed
Restrictions on advertising of contraceptives in media	Nominally open; campaigns for unmarried couples challenged
Absence of unwarranted restrictions on providers	Draft guidelines to clarify responsibilities
Absence of unwarranted restrictions on users	Draft guidelines to harmonize precautions; focus on youth
Public sector resource devoted to FP as percentage of GNP	Data not available
Quality of program leadership	Respected international expert as Chairman of NPC
Extent of commercial sector participation	GSMP market share of condom sales is 40%

## APPENDIX 8

### IEC Materials Produced

#### Public Sector

MCH/FP and HIV/AIDS posters (nine different)	308,030
Service Provider "I Care" Badges	2,000
Leaflets (five kinds FP and Health)	1,300,000
Booklets (AIDS.. two kinds by GSMF and ODA)	467,000
Clinic Signboards and SDP stickers	1,700
Flip Charts (received)	200
Cue Cards (received)	500
Billboards (FP and AIDS from FPHP and ODA)	152
Quarterly newsletter (8 issues)	80,000
Videos (set of five to each region AIDS/FP)	50

#### Private Sector (GSMF)

Radio Spots	5,006
TV Spots	1,405
Cinema video spots	8,316
Billboards	125
Posters	102,000
Flags/Banners	60
Mobiles	15,000

**APPENDIX 7**

<b>FPHP: PERSONS TRAINED</b>	
<b>Cadres Trained</b>	<b>Numbers</b>
Private Midwives (GRMA)	127
TBA Refresher Training	850
Nurses and Midwives (MOH and private)	493
AVSC Counselling for Nurses	134
NORPLANT and minilap (Doctor-Nurse teams)	76
Pharmacists and Chemical Sellers	4580
NGO Leaders and CBDs	500 (approx)
Regional & District service providers, health educators and community leaders	not known

APPENDIX 8

**FAMILY PLANNING SERVICE DELIVERY POINTS**

Type of Service Delivery Point	Number
<b>Ministry of Health</b>	
Regional Hospitals	11
District Hospitals	41
Health Centers and MCH centers	524
Outreach Posts (sometimes monthly visit)	880
TBAs trained in FP	4,025
<b>GRMA (private midwives)</b>	<b>378</b>
<b>GSMF</b>	
Pharmacists	309
Chemical Sellers	4,309
Supermarkets and shops	50
Bars, hotels, filling stations	455
Hair dressers	95
CBDs of NGOs	500
Private physicians	50
<b>PPAG</b>	
Clinics (excluding MOH co-located clinics)	26
CBDs	850
<b>Other Private Sector hospitals and physicians</b>	<b>408</b>

Source: MOH 1993 Annual report and GSMF reports

**APPENDIX 9  
FPHP PIPELINE DOLLAR ANALYSIS**

March 31, 1995  
(US\$ 000s)

	Budgeted Obligated	Committed	Accrued Expenditures	Pipeline	Available
Institutional Contractors	\$7,000	\$6,000	\$4,816	\$1,184	\$1,000
Buy-ins to Central Agreements	\$1,806	\$1,746	\$1,337	\$408	\$60
Direct Grants and Cooperative Agreements	\$2,200	\$1,792	\$694	\$1,098	\$408
Project Support	\$4,028	\$3,001	\$1,915	\$1,086	\$1,028
Financial Analysis, M&E	\$466	\$423	\$234	\$169	\$43
			\$8,996	\$3,965	
<b>Total FPHP</b>	<b>\$15,500</b>	<b>\$12,961</b>			<b>\$2,539</b>

The Expended portion of Committed funds includes expenditures reported by USAID/Ghana. Some under-reporting exists in this item due to omission of expenditures recorded by USAID/Washington contracts not yet communicated to USAID/Ghana.

APPENDIX 10

FPHP Pipeline Percentage Analysis, March 31, 1995				
	Percent Committed	Committed <sup>2</sup>		Percent Available
		Expended	Pipeline	
Institutional Contractors	86%	80%	20%	14%
Buy-ins to Central Agreements	97%	77%	23%	3%
Direct Grants & Cooperative Agreements	81%	39%	61%	19%
Project Support	74%	64%	35%	26%
Financial Analysis, M&E	91%	55%	45%	9%
		69%	31%	
<b>total FPHP</b>	<b>84%</b>			<b>16%</b>

The EOP data is scheduled for early 1996.

2. The Expended portion of Committed funds includes expenditures reported by USAID/Ghana. Some under-reporting exists in this item due to omission of expenditures recorded by AID/Washington contracts not yet communicated to USAID/Ghana.