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CLASSIFICATION

PROJECT EVALUATION SUMMARY (PES) - PART I

Report Control
Symbol U-447

1. PROJECT TITLE 46232 TOGO FAMILY HEALTH CENTER			2. PROJECT NUMBER 693-0212	3. MISSION/AID/W OFFICE USAID/Togo
5. KEY PROJECT IMPLEMENTATION DATES			4. EVALUATION NUMBER (Enter the number maintained by the reporting unit e.g., Country or AID/W Administrative Code, Fiscal Year, Serial No. beginning with No. 1 each FY)	
A. First PRO-AG or Equivalent FY <u>77</u>	B. Final Obligation Expected FY <u>78</u>	C. Final Input Delivery FY <u>86</u>	<input checked="" type="checkbox"/> REGULAR EVALUATION <input type="checkbox"/> SPECIAL EVALUATION	
6. ESTIMATED PROJECT FUNDING			7. PERIOD COVERED BY EVALUATION	
A. Total \$ <u>1,278,000</u>			From (month/yr.) <u>10/83</u>	
B. U.S. \$ <u>1,278,000</u>			To (month/yr.) <u>12/85</u>	
			Date of Evaluation Review	

8. ACTION DECISIONS APPROVED BY MISSION OR AID/W OFFICE DIRECTOR

A. List decisions and/or unresolved issues; cite those items needing further study. (NOTE: Mission decisions which anticipate AID/W or regional office action should specify type of document, e.g., airgram, SPAR, PIO, which will present detailed request.)	B. NAME OF OFFICER RESPONSIBLE FOR ACTION	C. DATE ACTION TO BE COMPLETED
Potential Actions upon Completion of Project		
1. Short-term Management Training for Project Director. Explore potential of Central funds of UC/Santa Cruz course in 1986.	Popp:GDO	9/86
2. Explore continue funding of project at current levels with or without FPIA participation as part of new Health Planning project (693-0228); including commodity support.	Popp:GDO	10/86
3. Explore continue FPIA technical assistance under FPIA-02, particularly in administrative and financial management.	FPIA/Nairobi Popp:GDO	11/86
4. Continued project monitoring to ensure training emphasizes IEC and increased impact on line clinic operations.	FPIA/Nairobi Popp:GDO	1/87

9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS			10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT	
<input type="checkbox"/> Project Paper	<input type="checkbox"/> Implementation Plan e.g., CPI Network	<input type="checkbox"/> Other (Specify)	A. <input type="checkbox"/> Continue Project Without Change	
<input type="checkbox"/> Financial Plan	<input type="checkbox"/> PIO/T	_____	B. <input type="checkbox"/> Change Project Design and/or	
<input type="checkbox"/> Logical Framework	<input type="checkbox"/> PIO/C	<input type="checkbox"/> Other (Specify)	<input type="checkbox"/> Change Implementation Plan	
<input type="checkbox"/> Project Agreement	<input type="checkbox"/> PIO/P	<u>Terminal Project</u>	C. <input checked="" type="checkbox"/> Discontinue Project	

11. PROJECT OFFICER AND HOST COUNTRY OR OTHER RANKING PARTICIPANTS AS APPROPRIATE (Name and Title)		12. Mission/AID/W Office Director Approval	
W. Ernest Popp, USAID/Togo/GDO		Signature <i>Barbara D. Howard</i>	
Dr. Vigino Devo, Director FPIA FHP		Typed Name Barbara D. Howard, Acting AID Rep	
		Date March 5, 1986	

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FINAL EVALUATION

TOGO FAMILY HEALTH

23 November - 20 December, 1985

FINAL REPORT

submitted by:

Dr. Sif Ericsson
Dr Liliane Toumi

January 24, 1986

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EXECUTIVE SUMMARY

The construction of the Togo Family Health Center was financed by a USAID grant. Family Planning International Assistance (FPIA), financed by another USAID grant, are responsible for training activities in family planning at the center. This final evaluation of the USAID Family Health Center grant was carried out November 25 through December 20, 1985. The grant to FPIA will continue until November 1986.

The evaluation was carried out by Dr. Sif Ericsson and Dr. Liliane Toumi. Dr. Ericsson was responsible for the overall evaluation while Dr. Toumi concentrated on the clinical aspects of the program.

Project implementation started in 1980 with the construction of a family health center, finished and equipped in July 1983. In October 1983 the first group of midwives was trained in family planning. Until now 121 health workers have been trained: 11 physicians, 54 midwives, 35 nurses and 21 social workers. Of these 10 of the physicians and 7 of the social workers were male. All of these health workers are currently involved in family planning activities.

The Center has given basic training in the different aspects of family health. The content of the courses seems appropriate and emphasizes the most important subjects. The stress is on interactive training methods to ensure active trainee involvement. The methods are effective, but the facilitators need training to improve their use of interactive teaching methods and to broaden their knowledge in family planning. Technical assistance is also needed to improve the curricula, teaching materials and the tests.

Family planning services are available in 11 clinics, 4 in Lomé and 7 in main cities outside Lomé. These services satisfy more or less the demand

from the acceptors. Service delivery is sometimes interrupted in Lomé when the midwife in charge is absent (vacation, training, etc.).

The current services are acceptable, but it is obvious that the health workers need more knowledge to deal with different situations, as more and more women use the services. Regular in-service training would allow the personnel to maintain or even increase the quality of the services when the demand for family planning increases.

Since the beginning of service delivery through the project (1983), 1992 couples have accepted a contraceptive method in the clinics serviced by the project. During the same time, ATBEF statistics indicate that around 12,000 couples use modern family planning methods. This represents circa 2% of all women in childbearing age. Approximately 4,000 of those have used family planning for more than one year.

In order of preference the most commonly used methods are: spermicide, IUD, and condom. The pill is used by very few women and the diaphragm by no one. Women prefer spermicides because they are familiar with the method and because it does not have any significant side effects.

Until now, the project has not engaged in any promotional programs, except that information is given during pre- and postnatal consultations. Currently there are too few health workers trained to carry out IEC activities. Thus, it is necessary to stress training of social workers and nurses in IEC. Men in Togo exhibit a certain resistance towards family planning. Since use of contraceptive methods in Togo requires the husband's permission, male health workers should be trained to inform, educate and motivate the men to use family planning with their wives.

In order to further spread family planning information, posters should be posted in public places, and flyers should be available for distribution by the health workers.

The staffs in the clinics work well with adequate medical supervision. No supply management system exists, due to lack of precise instructions and support from the project administrators in Lomé. The clinics are managing on their own, obtaining contraceptives and other materials without assistance from the project. This situation has led to stockouts of contraceptives, especially spermicides, which is the most preferred method. The staff in Lomé should establish a management information system which allows them to renew supplies at the clinics on a regular basis.

It is also obvious that there are problems associated with the registration of acceptors. This is mainly due to the form used. A new system should be instituted which is easier to use. Currently, collection of statistics depends totally on irregular visits by project staff in Lomé. At this stage of the project regular bimonthly supervisory tours should be scheduled and carried out.

It is important to organize a management strategy which allows the project staff to plan and guarantee service delivery both in existing centers and in future centers. This plan should include a system for collecting statistics and for using the administrative staff as effectively as possible. The project manager and the rest of the staff would benefit from training in management and administration.

The project staff has had problems with FPIA. For example, transfer of funds has not been done in a timely manner and FPIA has not given sufficient technical and managerial assistance. It may be necessary to investi-

gate other alternatives for such assistance in order to provide more direction to the project.

The following recommendations are the most important:

1. The personnel responsible for administration of the project should receive management training.
2. The facilitators should also be trained in order to improve their teaching methods and knowledge in family health.
3. Trainees should be selected so that:
 - a. each main town in a prefecture has personnel trained in family planning available.
 - b. in each family planning center the team includes staff which can inform and educate the public, especially the men.
 - c. more male staff is trained.
4. Each clinic should have a supply of educational materials which can be used to promote family planning in the community.
5. Work schedules should be arranged so that family planning services are available all the time the clinics are open.
6. Supply management, especially of contraceptives and antiseptics, should be arranged so that stockouts are avoided.
7. Regular in-service training should be given in Dapaon, Kara-Sokodé, Atakpamé and Lome, so that staff can improve their knowledge and delivery of family planning services.
8. A better and more functional system for registration of acceptors should be instituted.
9. FPIA should improve the methods used to transfer funds since the delays in such transfers causes problems with implementation of the project.

TOGO FAMILY HEALTH CENTER FINAL EVALUATION

INTRODUCTION

The Togo Family Health Project is composed of two closely integrated projects: USAID Togo Family Health Center 693-0212 (TFHC), a bilateral grant and FPIA Togo-2, A USAID-funded grant awarded to Family Planning International Assistance (FPIA). The TFHC 693-0212 constructed a training center and provided some technical assistance, secretarial services and commodities. FPIA Togo-2, a 38-months grant (October 1983 - November 1986) has trained 121 medical professionals and initiated services in 9 clinics. During the remaining time of the FPIA grant, an additional 85 medical professionals will be trained and commodities and contraceptives will be provided for 12 centers.

The TFHC was initially conceived in 1976, but implementation was not started until 1980. The TFHC is attached to the WHO training center in Lomé. This final evaluation will build on the mid-term evaluation conducted by Dr. Maria Waver in March 1984. This evaluation will review the project activities since March 1984, and make recommendations for the future. The construction of the center and the initial development of the program will not be discussed in this report.

The evaluation team consisted of Dr. Sif Ericsson and Dr. Liliane Toumi. Dr. Ericsson was responsible for the overall evaluation while Dr. Toumi concentrated specifically on the clinical aspects of the program. The evaluation was conducted November 23 to December 20, 1985. The team visited 7 clinics; 4 in Lomé, and 3 in the interior of the country and reviewed project documentation at USAID and TFHC.

ACHIEVEMENTS

The project achievements will be evaluated in terms of the planned end of project status (EOPS) for the TFHC project.

EOPS 1a: The Family Health Center will have been constructed and equipped by 1/80.

Construction of the center was completed in July 1982. The facilities were equipped by July 1983.

EOPS 1b: The Center will be fully staffed with qualified Togolese personnel.

The Government of Togo (GOT) has assigned six full-time persons to the Center, three trainers, an administrator, an IEC coordinator and a clinical coordinator. The three trainers have been with the project since January 1982, the administrator and the IEC coordinator since October 1983 and the clinical coordinator started in October 1985.

EOPS 1c: The Center will develop curricula for middle and lower level personnel and student training by 10/80.

The Center will provide in-depth training in the various aspects of family health for medical, paramedical and social personnel.

Curricula have been developed for training in family planning for physicians, midwives, nurses and social workers. Training of medical, paramedical and social worker students has not been considered.

The following courses have been held at the Center:

1: 12 midwives 10/12 - 11/25 1983

2:	20 nurses	1/30 - 3/16 1984
3:	11 physicians	4/16 - 5/25 1984
4:	21 midwives	6/25 - 8/17 1984
5:	21 midwives	1/21 - 3/15 1985
6:	21 social workers	4/29 - 5/31 1985
7:	15 nurses	10/14 - 11/29 1985

The following courses are planned for 1986:

1:	social workers	1/20 - 2/14
2:	midwives	3/10 - 5/2
3:	social workers	6/2 - 6/27
4:	physicians	9/1 - 10/10
5:	medical assistants	11/10 - 12/19

EOPS 2: Introduction of family health services, including family planning by well-trained personnel, in at least one MCH or health center in each of the 21 health districts of the country.

The following centers have been designated by GOT as family planning centers and are currently operational:

LOME:	Clinique de Bé (Centre de Santé)
	Clinique de Zongo
	Clinique du Centre Communautaire de Tokoin
PREFECTURES:	Centre Hospitalier Regional de Dapaon
	Centre Hospitalier Regional de Kara
	Centre Hospitalier Regional de Sokodé
	Centre Hospitalier Regional de Atakpamé
	Hôpital de Kpalimé

Hôpital de Tsévie

Hôpital de Aného

In addition, a privately run clinic, clinique de l'ATBEF (Association Togolaise pour le Bien-Etre Familial), is used as a training center.

ATBEF is providing contraceptives for GOT clinics in all 21 prefectures. Personnel trained at TFHC, but not assigned to a TFHC project clinic is usually providing services in a clinic serviced by ATBEF.

EOPS 3: The following MOH personnel will have been trained or retrained; 88 % of doctors; 85 % of midwives, 95% of auxiliary midwives and 50% of social workers.

As of December 1985 the TFHC had trained: 11 physicians, 54 midwives, 35 nurses and 21 social agents for a total of 121.

The current training schedule calls for the training of an additional 25 physicians or medical assistants, 10 midwives and 50 social workers. Thus, by the end of 1986 approximately 200 health professionals will have been trained. This represents a much lower percentage of trained MOH health personnel than called for in the EOPS.

EOPS 4: Sex education materials will be provided for all secondary schools and additional sex education materials prepared for all primary schools.

Sex education materials have not been provided under the project.

EOPS 5: 10 % of married couples using a modern method of contraception within 5 years of full operation of the center, i.e., FY85.

The initial FPIA grant had as a goal the provision of family planning services to 8,000 acceptors in 1984. The FPIA project has reported 1,992 acceptors within the currently designated service centers. ATBEF statistics which include FPIA acceptors indicate that during 1984 about 12,000 couples in Togo used family planning services of which 4,000 were old acceptors.

The estimated population of Togo in 1985 was circa 3 million. Approximately 600,00 were women between 15 and 45. Thus, currently about 2% of all women of childbearing age are using modern contraceptives.

COMMENTS

This section of the report will include the team's observations during the evaluation and identify the main problems.

Equipping the Family Health Center

The Center has the minimum amount of materials and supplies necessary to carry out the training. The facilitators would like to have more pelvic models for simulation of the clinical training, which is planned for in the current FPIA contract.

On the other hand, there seems to be a general lack of audio-visual aids and of support materials for the facilitators in family planning, health education and training. There is very little reference materials in the library in training and health education, partly because there is not much available in French. USAID has provided some family planning literature for the Center, but the facilitators do not fully utilize these resources. One rea-

son is that it is difficult for them to relate the information in the literature to their own experiences. At this time, the library is seen more as a resource for the trainees, and the facilitators do not use the library. Many factors account for this, of which perhaps the most important is that they do not see independent reading and studying as part of their job.

It would improve the effectiveness of the training center if the facilitators would use the reference materials in the library more. In addition, the Center should try to acquire additional "how-to" materials in health education and training and use them to get ideas for their training delivery. Similarly, the facilitators need to have access to a wide variety of IEC (information, education, communication) material, even if it is not actually used in the IEC activities in Togo.

Training

Curricula: Curricula exist for the courses for midwives, physicians, nurses, and social workers. (Course objectives--but not the subobjectives--are listed in Appendices 1 and 2) Only physicians and midwives are trained to insert the IUD and dispense other contraceptives. Nurses and social workers are mainly trained in IEC so that they can participate in the promotion of family planning needed to motivate more Togolese to use contraceptives.

All curricula include objectives and are organized in modular form. The curricula are very similar. (See Appendix 3 for course schedules.) The courses for physicians and midwives are practically identical. The midwife course is longer since more clinical practice is included.

The nurse and social worker course also differ primarily in terms of time allotted to clinical practice and family planning. The facilitators had

planned to use the nurse curriculum for the next social worker course. However, due to financial constraints, FPIA reduced the course time to 4 weeks (20 days). To give the social workers 3 days for practical work in the clinic the training module may be eliminated and the introductory module reduced to 3 days. In addition, by changing the content, the module on managing family health programs could be reduced to 5 days. However, it would be even better to extend the course by 5 days to include some more practical experience and training in communication.

Other suggestions for improvements of the curricula include:

1. Start the clinical practice early in the second week for the physicians and midwives, and continue this practice throughout the course to allow maximum opportunity to practice inserting IUDs. (In two of the training clinics IUDs are inserted only one day a week.)
2. Condense the module on managing family planning to 6 days (10 for physicians) in all courses to allow more time for clinical practice. This may be accomplished by providing a standard form for the field trip and by making the problem-solving exercise more practical.
3. Include some other topics of family health in the curricula for nurses and social workers.

The curricula suffer from lack of job descriptions for the various categories of health personnel which are trained at the Center. Presently, the facilitators include everything they think may be needed. With clear job descriptions the facilitators could define the tasks more clearly and thus improve the focus of the training. Even before such job descriptions are produced, we recommend that the IEC and clinical coordinators try to define the tasks and problems at the clinics and communicate these to the facilitators, so that they can adjust the training to the needs of the trainees.

Currently, the courses deal almost exclusively with family planning issues. Areas such as problem identification and planning, supervision and management of family health projects, nutrition, sanitation, and child and maternal health are not given sufficient attention in the courses. It would be preferable to teach some of these subjects independently. Examples of separate courses are management, supervision, training, and health education in nutrition, sanitation and other family health subjects. Short courses (one to two weeks) should be given in these subjects regionally based on needs identified by the project staff in each region.

Training materials: The courses use mainly short mimeographed articles developed at the WHO training center for other courses. Materials which deal specifically with family planning have been taken from a manual developed by IPPF. Some of the articles are too theoretical and broadly based. This creates problems for the trainees who have difficulty using the theoretical concepts in a practical context.

The trainees are supposed to spend time in the library studying the additional resources available there. In actuality, very few trainees take advantage of this opportunity, feeling that the assigned readings are more than sufficient. As practitioners they have not had much opportunity to read and that is reflected in how they approach the training course. This puts additional pressure on the facilitators since almost all of the learning must come from verbal communication in class.

In order for the trainees to benefit optimally from their studies, the teaching materials need to be adapted to conditions in Togo and has to be more practically oriented. More attention to how the theory can actually be used in Togo and more case studies would improve the readings.

Tests: In each course the pre- and posttest are identical. Although different courses do not use the same test, there is considerable overlap among the questions. Also, at the end of each day they are asked if any of the content covered during the day needs further clarification. If necessary, such clarification is given before any other activity is undertaken.

The tests used in the courses suffer from the same problems as the training materials. Generally, questions evaluate if the readings have been assimilated and understood, and do not try to assess how well the trainees can apply the theoretical content. The facilitators are aware of the problem but do not know how to change the tests. In all fairness, it should be said that it is very difficult to write test questions which assess the application of theoretical knowledge.

The final evaluation score (maximum 20 points) is composed of three parts: the score on the posttest (10), the evaluation of clinical skills (5) and an assessment of the trainee's group participation (5). A trainee must have a composite score of 12 to graduate. Although in principle he or she can do so, with a 0 in clinical skills, trainees have to meet a certain clinical standard to pass the course. Evaluation of clinical skills will be discussed again with the clinical training.

Training delivery: The facilitators have adopted the training method used at the WHO training center which focuses on the use of interactive training methods and encourages the trainees to take responsibility for their own learning. The technique assumes that trainees read the assigned materials which are clarified in class and followed by group or individual work. Each

module is reviewed and summarized and the course ends with a general synthesis of all the modules.

There are some general positive aspects to this format. All of the facilitators are very conscious of the need for interactive training methods, the need to review materials, the need to make sure everyone has grasped the concepts before continuing, and the need to review and change courses taking into account the needs of the trainees.

Although the facilitators are committed to using interactive training methods, they have certain problems in the classroom. They have a basic understanding of and are committed to the training philosophy and methods used at the WHO training center, but they do not have the real flexibility which comes from broader and more in-depth training and practical experience in family planning and primary health care. In addition to more experience, they need exposure to good role models. They also do not have an adequate knowledge of family planning, supervision and management

Consequently, they do not insist sufficiently on the practical application of the skills taught in the course. They have difficulty providing realistic examples to clarify theoretical issues and they do not take adequate advantage of classroom opportunities for trainee interaction.

Clinical experience gained through participation in the supervision of former trainees could give the facilitators information about what practical aspects to stress in the courses and also assist them in determining what changes might be needed in course content.

Courses abroad would stimulate and increase their knowledge and also provide valuable exposure to other trainers. However, selection of such courses should be done with care so that the training they receive does not directly conflict with the model they have adopted and are comfortable

with. Two of the facilitators participated in a WHO course in Mauritius. The training consisted of lectures with a few field visits. This course gave them neither practical experience nor exposure to interactive training methods. As a result, both of them gained very little from the course. The training they need most urgently is in **actual delivery** of courses, building on what they already know and are doing. In addition, they need a better theoretical understanding of family planning, management and training techniques.

The optimal training would be technical assistance in which an experienced family planning practitioner/trainer spends time with them to transmit more knowledge in family planning and in basic training methods. This consultant would have to work with them in the classroom and clinic delivering the courses they are already giving. In addition, assistance should be provided in modifying the curricula, training materials and tests. However, the general resistance to technical assistance which exists at the Center should be taken into account. There is serious doubt about the effectiveness of technical advisors and a fear of losing control of their own activities. If possible, TFHC personnel should be actively involved in working out the scope of work and in selecting the consultant.

Clinical Training

The clinical training is conducted at the four family planning centers in Lomé; the clinics in Bé, Tokoin and Zongo and the ATBEF clinic.

For the physicians and midwives the clinical training consists of insertion of IUDs, assisting the acceptors in choosing the best method, and managing side effects and complications. (See Appendix 1.) Physicians have six 4-hour sessions and midwives twelve 4-hour sessions in the clinic. The

clinical practice is preceded by two 3-hour session of simulation of IUD insertion. (See Appendix 3.)

For the nurses and social workers the practical training includes information and education. The nurses have four 3-hour sessions in the clinic. The first course of the social workers did not include any clinical practice. However, subsequent courses for them will include at least three sessions in the clinic. (See Appendix 3.)

Before each course, the staff at the Center and at the training clinics meet to discuss the strategy and organization of the clinical training.

It was impossible to observe actual training in clinical skills because no course was given during the evaluation period.

Skills of clinical trainers: The actual training at the four clinics is given by the head midwives with participation by Center staff as observers and supervisors.

Since no training was carried out during the evaluation, it was difficult to assess the training skills of the midwives at the clinics. It should be noted, however, that none of them has had any training in how to train. In addition, the facilitators at the Center are not sure that the trainees are adequately guided and supervised at the clinics when they are not present.

The clinical skills were also difficult to assess since at three of the clinics the responsible midwife was not performing services on the day of our visit. At the fourth clinic, we observed counseling of acceptors and treatment of complications, but no insertion of IUDs. The activities we observed were carried out in a generally acceptable manner.

Certain inferences can be drawn from our observations. At all four clinics the head midwife has had additional training in family planning out-

side Togo. All of them seemed competent and knowledgeable. Also, a review of the charts indicated that only a few IUDs had to be removed. The facilitators at the Center said that despite repeated demands the midwife at Zongo did not follow the protocol agreed upon for insertion of IUDs. This confused the trainees. The gesture omitted by this midwife tends to make it more difficult for an inexperienced midwife to insert the IUD, but it is not per se wrong to omit the gesture. Thus, their clinical skills seem to be at least adequate.

For the training of the nurses and social workers in how to motivate clients and promote family planning there seems to be inadequate supervision and guidance. None of the clinics (except possibly the ATBEF clinic) seems to have personnel sufficiently trained and able to guide the trainees during their clinical practice.

The three facilitators at the Center have no experience in inserting IUDs (except in the classroom) and would like to be proficient in this skill. The clinical supervisor, however, has such training. None of the staff at the Center has practical experience in carrying out IEC activities. The IEC coordinator has attended a course in United States but has not actually worked promoting family planning in a clinic or community.

Number of acceptors: Currently the midwife course schedule allows for 12 consecutive days of clinical training (two weeks). At all government clinics the acceptance rates are very low. (See Appendix 4.) The average monthly acceptance rate per clinic is 4 to 6 IUDs. Thus, 1-2 IUDs are inserted each week in the government clinics for a total of 6-12 during the clinical training. At the ATBEF clinic trainees are able to insert approximately 100 IUDs during the training for a total in all clinics of circa 110. Thus in a

course with 15 to 20 trainees each one may insert 4 or 5 IUDs. It is generally agreed that each trainee should insert at least 10 IUDs under supervision before she can practice on her own.

The number of acceptors at the training clinics is clearly insufficient for the midwives and physicians to learn how to insert the IUD with proficiency. So far, most midwives inserting IUDs have either received additional training outside the country or been further trained by the physicians working at the same hospital.

At this time very little can be done to increase the number of acceptors at the different clinics. The only solution would be to decrease the number of trainees or to revise the course schedule so that the midwives spend more time at the clinics during their training.

Evaluation: The midwife trainees are evaluated by the midwives in the clinics during the clinical phase. Their observations are guided by an evaluation form developed at the Center (Appendix 5). The midwives are supposed to use this form together with the step-by-step procedures developed at the Center. The main problem is that the midwives at the different clinics do not agree on what constitutes a serious mistake and what can be accepted. Thus, the facilitators and the clinical coordinator are currently trying to develop guidelines for this evaluation.

The evaluation of the nurses and social workers uses a similar form. They are also evaluated by the personnel at the clinic. In this case the reliability of the assessment is even less, since the steps have not been defined clearly enough. The facilitators and the IEC coordinator are trying to deal with this problem.

Establishing Clinics

Number of clinics: Currently the government has designated 11 clinics as family planning clinics, 4 in Lomé and 7 up-country. Of these, one (CHU) is not operational due to lack of facilities for family planning activities. The Zongo clinic has been operating since 1974. The other two centers in Lomé were opened in 1984, Atakpame, Kara, Sokodé and Dapaon opened in 1984 and Aného, Tsévié and Kpalimé were opened in the first part of 1985.

In addition, ATBEF has been authorized to provide family planning services in a clinic (opened in March 1983). ATBEF also has regional offices in each prefecture which provide motivation for and promotion of family planning. ATBEF also provides GOT facilities (mainly clinics for maternal and child health--PMIs) in the main towns of each prefecture with contraceptives. The PMI in Sokodé has provided services since before 1982. Thus, services are widespread and available in all 21 prefectures.

The government's approach is to proceed slowly and to make sure that the clinics already opened are well received by the population and function well with no shortages of contraceptives and other materials. This makes it hard to predict when more clinics will be included within the FPIA project. However, it seems possible to have a sufficient number of physicians and midwives trained at the end of 1987 to open a clinic in each prefecture.

Personnel: Currently all clinics are supervised by a doctor or midwife who has had training in family planning abroad. The clinics outside Lomé have physicians working in the family planning clinic and all clinics have at least one trained midwife. In addition, other midwives, nurses and social workers have been trained and associated with the clinic. (See Appendix 6.)

Sufficient personnel have been trained at CHU, Centre de Santé de Lomé and Casablanca for these three facilities to be approved for family planning activities. Outside Lomé, midwives or physicians have been trained in 8 prefectures apart from the 7 in which services are provided now. According to the IEC coordinator and Mrs Mensah (ATBEF) these people provide family planning services with contraceptives supplied by ATBEF. It would be possible to include these centers within the FPIA project.

Thus, 11 centers (3 in Lomé and 8 up-country) already have personnel trained for family planning services and could be included in the project. Training is still needed for personnel in the other 6 prefectures. Since the project is training at least 10 midwives and 10 physicians in 1986 it should be possible, with careful selection of trainees, to have personnel able to deliver family planning services in each prefecture at the end of 1986.

It should be noted, however, that IEC staff is still not trained for all existing centers. Even with careful selection of trainees there will not be a sufficient number of social workers or nurses trained to provide IEC activities in all prefectures by the end of 1986. However, all existing clinics should have trained midwives, nurses and social workers at the end of 1986.

Equipment of centers: FPIA has provided equipment to all functioning clinics. It should be noted, however, that all necessary equipment was not available when the clinic opened. Actually, there are still a few items missing at each center although it does not seem to impede the operation of the clinics. In only one clinic, Dapaon, did the lack of an examination table impede the activities. If a woman wanted an IUD, the first consultation was done in the family planning clinic while the insertion was done in the physician's office. This affected the collection of data and the follow-up of

the acceptor. A list of currently missing items is attached (Appendix 7). The most critical items missing seem to be lamps, fans, balances, and a container for instruments. Heat sterilizers are also necessary.

Laboratory: At all clinics in Lomé the head midwife pointed out the problems associated with lack of laboratory facilities. This did not seem to be a problem at the regional clinics since all hospitals have laboratories. The need for laboratory facilities arises especially with regard to the use of pills, since clinics in Lomé (but not in other areas) require extensive and expensive laboratory work before the pill is prescribed. Thus, most women decide to use another method or none at all.

In our opinion the laboratory work required is excessive. The minimum requirements are: clinical examination and medical history, blood pressure, and urine or blood analysis for sugar and albumin. Thus, the only laboratory work required is a simple blood or urine analysis. Given this, laboratory facilities are not really required for the clinics.

However, laboratory facilities are needed for proper diagnosis of genital infections. This would enable more adequate treatment of infections which may cause infertility. For acceptable performance at these laboratories training of the personnel is needed as well as equipment. Given the early stage of the family planning activities we do not consider a laboratory at each clinic necessary at this time.

Function of the Clinics

Supplies of contraceptives: Until now the only supplier of contraceptives has been IPPF through ATBEF. FPIA has provided some Conceptrol to evaluate the women's acceptance of this brand of spermicide. The reliance on

ATBEF has lead to sporadic shortages of contraceptives, especially spermicides.

The previous contract with FPIA did not exactly specify where contraceptives would be obtained. However, since ATBEF had already provided spermicides to some of the clinics in the project and was the sole supplier of contraceptives in the country, an informal agreement between the project staff and ATBEF allowed the project to assure clinical services without FPIA-supplied contraceptives.

The current contract with FPIA specifies that FPIA will provide contraceptives on a regular basis to the designated clinics. However, ATBEF will continue to give contraceptives to other clinics and may provide them to the project if shortages occur and ATBEF has contraceptives in stock.

Table 1 (Appendix 8) shows the women's preferences for contraceptive method. The pattern of contraceptive use is the same at all clinics (except Kara). Spermicides is the most commonly used method followed by IUDs and condoms. The pill is not acceptable to most Togolese families, especially in Lomé. The laboratory tests required in Lomé prohibit the use of the pill for most women. In other areas the pill is mainly used by educated women. EMKO (a spermicide) has only recently been introduced as a contraceptive and has not been available outside Lomé.

The main objective of the program should be to ensure that sufficient supplies of spermicides, IUDs and condoms are on hand to avoid shortages. The order received from FPIA in November 1985 seems to have provided a sufficient supply of IUDs and maybe condoms. However, the supply of spermicides, if the woman accepts Conceptrol instead of Neosampoon, is clearly not enough. We recommend that additional supplies of Conceptrol be provided by FPIA. The FPIA representative indicated that would be arranged.

Other disposable materials: Only gloves are supplied regularly by the project. USAID has, as a one-time measure, provided a supply of antiseptics, cotton and gauze. In addition, FPIA has supplied 5 pregnancy test kits for 11 clinics. These have not been distributed, since the instructions for their use are in English. Dr. Toumi indicated that the same pregnancy tests are distributed in France and that French instructions can be obtained from the manufacturer. Also, the project staff has not yet decided which clinics should receive a kit.

At this time there is a sufficient supply on hand of everything except pregnancy tests. However, even though for the immediate future there are no problems with the supply, it is as important to provide these on a regular basis as it is to provide contraceptives.

It is anticipated that the government will ensure a regular supply of antiseptics, cotton and gauze. Staff at the family planning clinics indicated that they had had some difficulty obtaining these materials. The regular allotments to the clinics and hospitals are not sufficient for the increase in services generated by the family planning activities.

To ensure the adequacy of the family planning services it is necessary for the FPIA project staff to review with the staff at the various clinics their needs for these disposable materials and discuss with the administrators in the hospitals to what extent they can provide them. It is recommended that FPIA supplements the government allotment as needed.

Medicines: Antibiotics, analgesics, antispasmodics and iron supplements are not provided by the project. When any of these medications are required the acceptor has to buy them from a pharmacy. Treatment of infections, side

effects and complications may not be ensured if the acceptor does not have the means available to obtain the medicines.

We recommend that the project staff investigates the possibility of obtaining a small renewable supply of medications to be used when women do not have the means for treating infections, side effects or complications.

Sterilization of equipment: In general equipment used at the centers is clean and properly sterilized according to acceptable norms. Antiseptic solutions, trioxymethylene tablets or dry-heat equipment are used. In Lomé only the clinic in Tokoin uses dry-heat.

Environmental factors: The size of the centers is adequate. In general, crossventilation is not provided which makes the offices stuffy towards the end of the day. Fans are needed to provide a more comfortable environment. Similarly, lighting is not adequate for clinical examinations. Lamps have been provided to some centers, but not to all, and general lighting still needs to be improved.

The maintenance and cleanliness of the centers depend on how long the facilities have been used. Obviously, it is harder to keep old facilities clean. It should be stressed, however, that all staff maintain the facilities as well as they can.

Specifically the following observations were made:

1. The clinic in Tokoin needs to be repainted and cleaned.
2. The clinic in Zongo needs window panes in the examination room to prevent dust from entering into the room.
3. The clinic in Zongo, although the floor has been fixed, still needs painting and minor repairs.

Service delivery: Family planning clinics are open the same hours as other health clinics. The availability of personnel for family planning services is not the same for all centers. None of the people participating in the clinical services work exclusively with family planning activities.

It would be desirable to have one person assigned exclusively to family planning activities. Given the current personnel shortages this is obviously not possible. Thus, an effort should be made to train all people working in the maternity and/or PMI so that when someone comes, information can be given by the person available at the time.

We recommend that as much as possible a woman receives contraceptives during her first visit and does not have to return. If the chosen contraceptive (IUD or pill) cannot be given at the first visit, another method should be prescribed until she can start with her preferred method.

All methods should be available each day the clinic is open. When IUDs are not inserted daily (as in Zongo), the woman has to return to have her IUD inserted. This may be inconvenient and may lead to a decrease in the number of IUD acceptors. The reason given was the need to sterilize equipment. We find this a weak reason and recommend that IUDs be inserted on a daily basis as is currently done in Bé and at the ATBEF clinic.

When only one or two persons can dispense contraceptives, services are interrupted during yearly vacations and other absences. For example in Zongo, although two midwives are trained, the family planning clinic was closed in December, since the head midwife does not allow the other one to insert IUDs without her supervision. Similarly, at the clinic in Tokoin only one midwife is trained, so when she is absent, no contraceptives are given out. The women are instead asked to go to the ATBEF clinic which provides services Monday through Friday.

The consequences of this disruption of services for one to four weeks is a decrease in the number of acceptors served by the clinic and a decrease in the women's use of the clinic for these services. If possible, arrangements should be made to ensure that family planning activities at the clinic are not disrupted during a midwife's absence.

Follow-up of acceptors: IUD acceptors are followed regularly according to a preset schedule. However, they do not always return. At most centers, the staff does not contact a woman to ask her to return for a checkup. Sometimes the address given by the woman is insufficient, but more often the staff has no time scheduled for home visits. Also the lack of transportation makes it impossible to visit women who do not live close to the clinic. Of course, these are usually the women who do not return.

Similarly, for spermicide and pill users more of an attempt to motivate the women to return for additional supplies should be made. When a certain time has elapsed, home visits should be programmed to find out why she has not returned and to encourage her to continue to use contraception.

Referral system: In Lomé, referral is to the gynecologist at the CHU or to a private physician. No follow-up is done to find out if the woman actually went to the physician.

In the regional facilities, referral is more direct, since a physician is working with each center. Thus a referral does not require the woman to go to another facility and follow-up is possible.

In general, the referral system seems to work well in the regional hospitals with the physician and midwives working as a team. In Lomé the lack of follow-up impedes the referral system.

Supervision: The clinics in Lomé are managed by one of the trained midwives who are in charge of all the activities. In regional centers the supervision is provided by a gynecologist.

Zongo: Two midwives have been trained. The midwife in charge has problems delegating responsibilities. For example, she will not allow the other trained midwife to insert IUDs on her own, although she indicated that the other midwife is capable of inserting IUDs.

Tokoïn: Only one midwife and social worker have been trained. The midwife is thus solely responsible for service delivery. Together with the other staff at the center she makes regular home visits to give information about family planning and other health services.

Bé: Five midwives and a physician have been trained at the clinic. The midwife in charge has taken the management course at the WHO training center in Lomé. She has delegated the responsibilities so that services are always available.

Regional hospitals: At the regional centers we visited, the physicians have provided additional training to the midwives and supervised their work until they were ready to work on their own. In addition, one of the physicians was supervising the record-keeping system.

The clinic in Kara seemed to have the best functioning supervisory system with responsibilities for record-keeping and stock inventory assigned to specific persons.

Profile of Acceptors

Number of acceptors: All clinics have a low number of acceptors. (See Appendix 4 and 8.) The low number is due mainly to the newness of the services and the lack of promotion and motivation for family planning, but

also to the way the women who come in for services are treated. We found real differences among the clinics in their attitudes towards acceptors. In general, family planning is viewed as something added to the personnel's other duties and as such, it has not been smoothly integrated into the work at the different clinics. The only clinic with the opposite attitude is ATBEF, which may in part explain the greater number of acceptors at that clinic.

With time, as family planning becomes more integrated with the other services this will change. Most of the people we talked with regarded it as a necessary and useful service.

The current efforts to train more nurses and social workers to provide information and motivation for family planning should increase the number of acceptors at all clinics.

Contraceptive use: The preference for type of contraceptive is different in Togo than in other countries. (See Appendix 8.) Worldwide, the pill is the most preferred contraceptive followed by IUDs.

Midwives explained the high use of spermicides by indicating that the women already knew about the method, and many had used it before. The lack of side effects also appeals to the women. The pill, as explained earlier, is not used in Lomé due to the excessive requirements for laboratory tests, and outside Lomé only educated women select the pill. The IUD is gaining in popularity. The main deterrent to its use seems to be the prevalence of infections which require treatment before an IUD is inserted or necessitate its removal.

Acceptor characteristics: The form used for clinical examinations provides information about the woman's age, ethnic background, religion, social

status, number of pregnancies, miscarriages, premature births, and living children. The form is only used for women who select the IUD or pill.

Togo requires the husband's permission before contraceptives are given, so practically all women are married. Unmarried women receive contraceptives only if they are self-supporting and a responsible relative signs the permission slip.

A quick review of 273 forms in Bé provided information about the acceptors number of living children. (See Appendix 9.)

According to this survey, 50% of all women using the IUD or pill have 3 children or less, while 75% have 5 children or less. Thus, it seems that women are using contraceptives for child spacing rather than to limit their families. It also probably indicates that younger women are more likely to use them, although actual statistics were not obtained.

According to Center staff another substantial group of acceptors, especially outside Lomé, consists of women who have many children, and who have had problems with a previous pregnancy or delivery. Such circumstances have made it easier to convince husbands to allow the use of family planning.

Thus, there are two major groups of users. One consists of young women using contraceptives to space their children. These women are probably married to younger, more educated men who are willing to allow their wives to use the services. The other group consists of older women with more children, who are close to the end of their childbearing and whose last pregnancy was troublesome and difficult.

It would be interesting to further follow up on this observation. The clinical examination forms could be used for such an investigation. (The data on the form also provides other information.) A study to ascertain

characteristics of the group of acceptors would provide results which could be used to guide the IEC activities. We strongly recommend research concentrating on characteristics of the acceptor population.

Continuation rate: No study has been made of whether women return for contraceptive services or not. With available data, it should be possible to evaluate the continuation rate for spermicide users, since its use requires that women return regularly to renew their supply. A rapid review of the cards in Zongo, showed only one or two return visits. According to the staff at the Center, the reason for this was the stockout of spermicides which occurred periodically during the last year. This summer they were without spermicides for 3 months. Thus, women have returned but been turned away due to the lack of supply.

The only IUD removals have been for medical reasons except one inserted in 1982. The project is just beginning to get some information about continuation rates, since the number of acceptors using the services during both funding periods is counted. The clinical coordinator has also introduced a form which asks the clinics to indicate the number of IUD removals and expulsions, and pregnancies with use of contraceptives. These statistics will provide further feedback on continuation rates.

Information, Education, Communication Activities

Background: The main objective of the family health project is to improve the health of mothers and children. Thus, the physician and midwife courses include information about nutrition, sanitation and personal hygiene. However, since the beginning of the project the main focus has been family planning. It was evident from our discussions with project personnel that

other areas of family health should remain part of the project training and maybe even receive more emphasis.

The focus of family planning in Togo is on child spacing which is not a new concept in Togo. Traditionally, prolonged breastfeeding and abstinence (by the woman) have ensured child spacing through the institution of polygamy and through sporadic separations. The activities of this project provides an alternative. This is especially important in urban and semi-urban areas where traditional methods are used less and less.

Project policy: Project family planning services are now only available to couples in urban areas. In order to avoid family disputes, project personnel insists that both partners participate in the selection of contraceptives and requires the husband's signed permission before contraceptives are given.

This requirement has posed some problems for the staff. Women are generally willing to accept the services but find it hard to persuade their husbands to participate. According to project personnel this male reticence is due not to a real desire to have closely spaced children, but rather to a fear that women to use contraceptives would commit adultery.

Another problem is the demand for contraceptives from unmarried women. The project staff in Lomé recommends that each woman's situation be considered on a case-by-case basis. The policy, adopted by some clinics which asks a responsible relative to sign the permission slip, protects the staff still makes contraceptives available to some unmarried women.

The marital permission requirement seems unnecessary when viewed from an outsider's point of view. However, in the current Togolese society with the constraints posed by social norms and traditions this requirement allows the project to initiate and implement family planning services with-

out creating resistance. We therefore see it as a measure which at this time protects the staff of the clinics from being party to disputes which could jeopardize the whole project.

Need for IEC activities: At this point the services are used mainly by women who have or are married to men with higher education. The information given at pre- and postnatal consultations are slowly bringing other women to the clinics. The clinic in Kara has mainly served hospital personnel and other government officials. Thus it is imperative to start activities which will:

1. Inform the population about when, where and how child spacing services can be obtained.
2. Provide information about which methods are available.
3. Give sufficient information about the different methods to allow a couple to choose an appropriate method.

In addition it is necessary for people trained in IEC to be able to assist a woman whose husband refuses to allow her to use contraceptives.

The men's reluctance to allow their wives to use contraceptives points to the need for an IEC campaign directed specifically at men. Our recommendation is that male nurses and social agents be trained to work specifically in this area.

Types of IEC activities: The current emphasis on IEC is thus both commendable and absolutely necessary. At the same time, it should be noted that provisions have to be made so that time can be spent on this activity. Hospital staff has special problems due to the scheduling of their work

time. Most nurses complained that they had very little time for IEC activities, especially home visits.

The information distributed so far has mainly reached women who have had direct contact with the PMI and/or Maternity or who work at the Hospital. The clinic in Tokoin is the only one with regularly scheduled home visits. At other clinics home visits are made only to check whether a woman is really unmarried, or to try to obtain the husband's permission for his wife's use of contraceptives.

We feel that more effort has to be made to free personnel to provide IEC. Home visits and informational meetings should be programmed regularly as part of their other duties. It is more a management and motivational issue than a problem of available time and personnel. Most people agreed that it would be possible to adjust the time schedule to allow some time for home visits and informational meetings.

The training of social workers will also improve the availability of personnel for IEC. The social workers are already including home visits in their daily schedule and some of them have limited transportation available. Thus they only need training to include family planning in the information they give during their visits and in village meetings and seminars.

ATBEF via its regional offices in each prefecture trains people to give information about family planning services at seminars and village meetings. The training is carried out in 4-5 day regional seminars. Similar training could be arranged by the project through the personnel at the Center in Lomé. Even though the courses currently given in Lomé prepare the trainees more thoroughly, short regional seminars could train more people in a shorter time.

Information should also be provided through posters, flyers and mass media. This would not only reach more people but also give a stamp of approval to the services which would encourage people to use modern child-spacing methods.

IEC materials: In order to carry out efficient IEC campaigns it is also necessary to have IEC materials. In our opinion the most effective materials would be flipcharts (for larger meetings and clinic talks), posters (in public places) and flyers which could be given out to men and women in the clinics and during meetings and home visits. The main function of these would be to increase motivation for and provide information about how, when and where child spacing services can be obtained.

Above all, materials should be made available to inform men about these services and the benefits they will receive from allowing their wives to participate in the program.

FPIA apparently does not have the means to produce materials especially adapted to Togo, but will be able to provide copies of materials used in other countries.

It is our recommendation that the project staff explore the possibility of adapting and reproducing locally the materials provided by FPIA. The Health Education department in the Ministry should be able to assist the project in this task.

The IEC coordinator has made a survey of the different clinics to assess their needs for IEC materials. Her list reflects the staff's general knowledge about possibly useful IEC materials. (See Appendix 10.)

Project Management

FPIA management: Among the various problems voiced by the project personnel probably the one which has disturbed them the most has been the difficulties of transferring money from New York to the project in Lomé.

To transfer money FPIA either hand-carried traveller's checks to Lomé or mailed money orders from New York. With either method it took a long time to have the funds credited to the account, and large fees were charged by the bank for the services. Also, apart from the initial transfer, additional money was not authorized until the quarterly report was received in Nairobi. Even if the report was mailed on time delays of one to two months were common before money was transferred. This created problems for the scheduled training courses and payment of salaries to project personnel. One course had to be cancelled due to the nonavailability of funds.

FPIA has now agreed to transfer money via bank draft through a bank in New York. This should have been done from the beginning.

Another problem which impeded service delivery was that adequate provisions were not made to assure a supply of contraceptives and antiseptics to the clinics. Also, in some cases equipment has not been available or quickly distributed to clinics. For example, the clinic in Dapaon waited from March to December to get an examination table.

These problems result from both lack of planning and implementation. Most of these problems could have been avoided or minimized if the planning had been adequate. However, plans must be aggressively pursued and persistently followed up in order to be realized.

For a new project like this it is necessary to provide substantial support, especially in planning and management. FPIA has not been able to pro-

vide this support, due to lack of adequate planning and a tendency to neglect supervision of project activities.

Similarly, the project at times needed technical assistance. It has been difficult for FPIA to identify such needs and to arrange for the consultants.

The report format used by FPIA does not provide sufficient information for adequate monitoring of project activities. The current report only serves to indicate that money has been spent on appropriate activities. Thus FPIA is sometimes unaware of problems and what assistance is needed. We recommend that the form be changed so that it can be used to monitor the activities more closely. This may also provide more of an incentive for project staff to complete the form on time and to work closely with FPIA.

Project management structure: The Ministry of Health in Togo has a centralized management structure. There is very little delegation of responsibility to lower levels. Some decisions could be made on a lower administrative level than is currently the case. For example, MOH in Lomé selects trainees rather than the project director or the Medecin Chef in the prefecture.

One result is that decision making is delayed since the lower level administrator cannot make the decision and the higher level administrator, because of his work load, cannot address different project concerns in a timely and systematic fashion.

The project is headed by a director who also is also responsible for the management of the PNEF (Programme National du Bien-Etre Familial). The day-to-day project implementation is carried out by the administrative, IEC and clinical coordinators at the Center.

The project director's office is not at the Center. This makes it difficult to communicate with him, especially since there is no telephone in his office. In addition, the project director's other duties make it impossible for him to pay full attention to the problems which occur. This puts more responsibility on the staff at the Center.

This limited access to the project director sometimes delays the decision making, even though the project staff has limited authority to take action during his absence. However, the coordinators are not likely to make decisions on their own. This increases the project director's responsibilities and also delays implementation of activities. The project director has instituted weekly meetings of all the staff. We encourage these regular meetings.

To improve communications between project director and staff a telephone should be installed in the project director's office. At this time, he has to leave his office to make a call and project staff has to visit him in order to consult with him. This is a waste of the project director's already scarce time and clearly reduces his overall effectiveness as well as that of his staff.

Management information system: Appropriate decision making requires pertinent, timely and sufficient information. This is even more important when the decision maker is not directly involved in the actual implementation of the decision.

Related to this aspect is the collection of data for the management decisions. For example, even though the project has been delivering clinical services since 1983, the project still does not have a system with information about what materials and equipment are available in each center and

what is needed. Attempts to survey the needs of the clinics, especially with regards to IEC materials, have been made. However, since no clinic has IEC materials, the survey did only provide a list of what staff knows about and would like to have at this time. Such a survey is only useful, if the goal is to find out what, among available materials, clinics would like to have. The main problem for the staff is selecting the data which need to be collected. In order to do this properly, they need training.

Thus, within the project, the staff should be trained in how to select and gather management information and in how to present it to the decision maker in such a form that his decision can be made taking into account all pertinent factors. Similarly, the project personnel should learn to anticipate decisions and to plan for the alternative decisions which may be made on the higher level.

Collection of service statistics: The number of acceptors at the clinics is registered on an FPIA form on which is recorded the name of the acceptor, address, date of visit, and type of contraceptive selected. Clinics are required to fill in two identical forms, one for themselves and one for the staff in Lomé. The second form is collected by the IEC coordinator when she visits the clinic.

In addition, a gynecological examination form (developed by ATBEF) is used for women who select the IUD or pill. This form provides more extensive data about the acceptor than the FPIA form.

The collection of data has not been done on a regular basis since data has only been collected during the program staff's visits to the clinics. Such visits have usually been scheduled quarterly in order to write the report required by FPIA. The coordinator has felt that she needed to have a copy of

the FPIA form before she could submit the data to FPIA. The reason for her concern is that the form is not always filled in correctly and the clinic staff often forgets to make a second copy.

In addition, when services are provided in more than one site (e.g., in the physician's office and in the maternity) the form is not always filled out for all acceptors. Thus, there are in some clinics more gynecological forms for IUD acceptors than there are FPIA cards.

It is our recommendation that the FPIA form be reviewed and the project staff investigates the possibility of using a system like the one used for vaccinations, with a register and a card given to the acceptor. This would simplify the work for clinic staff, especially with regard to follow-up. It would also provide a system which clinic staff is already familiar with and thus would have less problems using. The midwives in Dapaon are already using such a register.

The clinical coordinator has provided another more comprehensive form for monthly reporting. The clinic supervisor is supposed to keep a copy for the clinic and send one to Lomé. The form is to be revised based on the comments by clinic staff after it has been used for some time. It was also stressed that all services delivered at the clinic should be combined on the form. This will probably provide better and more timely statistics than the FPIA forms.

IEC activities are to be reported on a similar form. The nurses and social agents are supposed to keep a record of their activities in a notebook and combine their reports on a form collected by the IEC coordinator during her bimonthly visits. The form needs to be revised, since it provides too detailed information and is confusing.

One issue that was not clear is why the information is collected. The coordinators and staff seemed to feel that the only reason was that FPIA required the information. Since the data is also useful for planning purposes this should be communicated during the training so that clinic staff will be more conscientious and take recordkeeping more seriously.

Establishing clinics: The equipment for the currently operating centers have arrived at the centers without prior planning and mostly as a function of the perceived needs by the FPIA coordinator. Lists of necessary minimum equipment for service delivery already exist and funds were available for acquiring the equipment. Thus, the project should have been able to anticipate the needs of each clinic and to provide all equipment at the clinics when services were initiated.

It is recommended that the project personnel produces a plan (GANTT chart) to follow when establishing new clinics, which sets down the lead time necessary for obtaining the minimum equipment needed to open a new center. It may be advantageous to make a survey of the sites for prospective clinics and to have on hand a list of the minimum materials each specific clinic would need. In that way the decision maker could be aware of the time between the actual decision and the start of service delivery. Similarly, it would enable the project to order equipment in a timely manner so that the lead time could be decreased.

Most clinics have opened without having a complete team on hand for family planning services. At this time it seems that clinics (except Tokoin) have sufficient personnel for service delivery, but not for IEC. Trainees for IEC should be selected so that a complete team is available at all existing clinics by the end of 1986.

Supply management: The family planning clinics have until now received supplies in an unsystematic and unplanned manner. No systems were set up for distribution of equipment, supplies and contraceptives. Thus, personnel at the clinics managed on their own without assistance from the project staff in Lomé. It is important, that the project personnel makes a plan for timely delivery of supplies. Arrangements have been made with Togopharma for the distribution of contraceptives, but this system has yet to be used. However, personnel at all levels will need training in how to calculate the quantity of contraceptives and other materials needed over specific periods of time as well as how to replace equipment as needed.

Supply management cannot depend on regular visits from the project staff in Lomé. It is necessary to schedule regular deliveries, based on use patterns at the clinics with adequate safety stock provisions. Also one person in each clinic should be in charge of ordering and recording the use of supplies and contraceptives.

Supervision: The project staff in Lomé is supposed to provide support services to the clinics and to visit them on a regular basis. So far such visits have only been made when a report has been due to FPIA to collect statistics. However, such visits were supposed to be made every other month.

We recommend that visits be made bimonthly and that these visits be programmed so that the staff not only gathers data, but also provide the training and support needed at each clinic. The coordinators should review the objectives for their visits before they leave Lomé, based on the problems or needs found during previous visits.

All personnel need to learn how to set priorities and how to program their time to take into account all the tasks they need to perform on a regular basis.

At the clinics, this would mean reviewing the work load of all trained personnel and adjusting the schedules so that:

1. A trained person is available the whole time the clinic is open to provide information to prospective acceptors.
2. Service delivery is available (including insertion of IUDs) all the time.
3. Home visits are programmed and done on a regular basis (at least one or two afternoons a week).

Implementation: At this time the main difficulty with implementing decisions and solving problems is the lack of adequate and persistent follow-up. There is a certain attitude among the Center project staff that solving problems is not within their job description, and that once a problem has been identified and brought to the attention of someone on a higher level they have done their work.

An example is the supply of contraceptives. In November 1984 an FPIA representative visited Lomé to resolve issues regarding the distribution and supply of contraceptives. At that time arrangements were made with Togopharma for distribution and quantities were decided for the next funding year (to begin in May 1985). For the project staff in Lomé this meant that contraceptives were ordered and they just had to wait for delivery. Actually, contraceptives were not ordered until the new FPIA contract was signed (August 1985) and the contraceptives were delivered in November 1985. The result of this lack of follow-up was a shortage of spermicides

Similarly, the fact that project staff had brought to USAID's attention that pelvic models were needed for the training of midwives and physicians was sufficient for them to assume that the models were ordered. Yet USAID did not receive a GOT request for pelvic models and consequently did not order them.

It is important that the staff learns how to follow up on decisions and to investigate possible solutions to problems in order to resolve management difficulties.

Thus, it is evident that training in management and administration is needed on all levels of the project, but especially for the staff in Lomé. It is also evident that the attitudes toward problem solving are different among the project staff in Lomé and the staff in the clinics. The staffs in clinics outside Lomé have more experience and ability to deal with and resolving problems than the staff in Lomé. A change in attitude is needed, as well as a clear accountability system for responsibilities.

RECOMMENDATIONS

The project, despite all its difficulties, has made definite progress since its implementation. The training of personnel is probably the most successful aspect of the project. At this time service delivery is available in 15 prefectures and at 3 government clinics in Lomé as a result of the project's training program. Personnel is also trained at 3 more clinics in Lomé (including CHU).

The number of acceptors should increase as IEC activities begin to have an impact and since contraceptives are now available. The work of ATBEF also tends to increase the number of acceptors.

Recommendations for improving the program are as follows:

Training:

1. Train the facilitators by providing technical assistance in which an experienced family planning trainer spends sufficient time, working with them in the classroom and providing them with more knowledge in family planning and in basic training methods.
2. Provide technical assistance to make needed changes in the curricula, training materials and tests. This assistance should be combined with the training of the facilitators.
3. Train trainers in all regions (and eventually in all prefectures) so that training can be done on the regional level as need arises.
4. Give short courses (one to two weeks) on the regional level in different family health topics based on the needs identified by the project staff in the region.
5. Selection of trainees for the courses should be done so that:
 - A. personnel is available in each prefecture. If that is done, the lead time for opening centers after the government decision is made will depend only on the availability of equipment
 - B. personnel is available at each center which can motivate and inform the population
 - C. male personnel is trained in family planning so that each center has someone whose main task is to deal with husbands.
7. The Center should acquire additional "how-to" materials in health education, training, management and supervision as well as a wide variety of IEC material in family planning, even if it is not actually used in IEC activities in Togo.

8. Separate some of the course topics into individual courses, e.g., training, management, supervision, and health education in nutrition, sanitation and other primary health care subjects.
9. Adapt the teaching materials to conditions in Togo and make them more practically oriented. Improve the readings by using more case studies and by paying more attention to how the theory can actually be used in Togo.
10. Revise the test in order to assess the practical use of the theoretical knowledge rather than only the memorization of the concepts.
11. Increase the social worker's course to 5 weeks or change the curriculum by eliminating the module on training, decreasing the first module to 3 days and reducing the module on managing family health programs to 5 days. This would give the social workers 3 days of practical work in the clinic.
12. Decrease the number of trainees in the midwife course or start the clinical practice early in the second week and continue to the end of the course in order to allow as much opportunity as possible for insertion of IUD's. (In two training clinics IUDs are only inserted one day a week.)
13. Decrease the module in managing family planning to 6 days (as for the physicians) in all courses to allow more time for clinical practice. This may be done by providing a standard form for the field trip and by making the problem-solving exercise more practical.
14. The clinical and IEC coordinators should try to define the tasks and problems at the clinics and communicate them to the facilitators.

tors. This would enable them to adjust the training to the needs of the trainees.

Service Delivery:

1. Include CHU, Centre de Santé de Lomé and Casablanca in the project.
2. Include in the project the 8 prefectures in which personnel have already been trained.
3. Make sure that all existing clinics have a complete team (with at least two midwives, one nurse and one social worker) by the end of 1986.
4. Train all people working in the maternity and/or PMI at the existing clinics so that family planning information can be given by anyone in the clinic.
5. FPIA should provide additional supplies of Conceptrol to the project to avoid stockouts.
6. Project staff should review with the staff at the various clinics their needs for disposable materials other than contraceptives and discuss with the administrators in the hospitals to what extent they can provide these materials. FPIA should supplement the government allotment as necessary.
7. The time schedules for clinic staff should be adjusted so that family planning services are available on a daily basis at all existing clinics, and so that home visits are included among the duties.
8. Try to ensure that women receive their chosen contraceptive during the first visit and do not have to return.

9. Program home visits to women who do not return for follow-up or for subsequent supply of pills or spermicides.
10. Provide fans to ensure a more comfortable working environment.
11. Provide lamps for use during examinations to all clinics and improve general lighting as necessary.

>

IEC Activities:

1. Male nurses and social agents should be trained to work specifically to try to motivate and inform men to allow their wives to practice family planning using modern contraceptive methods.
2. Make more of an effort to free personnel to provide IEC. Program home visits and informational meetings as regular parts of the family clinics work.
3. Provide information through posters, flyers and mass media.
4. At this time no IEC materials is available at the clinics. Materials provided by FPIA should be reviewed, adapted and reproduced in Togo. The Health Education department in the Ministry should be asked to assist the project in this task.
5. Provide IEC materials to promote family planning especially designed for a male audience.

Management:

1. The project director should, if possible, participate in a course in management of family planning. In addition, short-term technical assistance should be provided to improve the administrative capabilities of the staff at the Center and to motivate them to take responsibility for following up on and implementing decisions.

2. Install a telephone in the project director's office.
3. FPIA should review its reporting system and change its form so that sufficient information is available to FPIA for careful monitoring of the project.
4. A system should be instituted so that timely delivery of supplies and contraceptives can be ensured.
5. The FPIA form used to gather acceptor data should be reviewed and the project investigate the possibility of instituting a reporting system like the one used for vaccinations, with a register and a card given to the acceptor.
6. Train project staff in how to select and gather management information and in how to present it to the decision maker in a clear and pertinent form.
7. Personnel at all levels should be trained in supply and drug management.
8. The project staff in Lomé should visit each clinic at least once every other month.
9. The bimonthly supervisory visits by the project staff in Lomé to clinics should be programmed so that the staff not only gathers the necessary data, but also provides the training and support needed at each clinic. The coordinators should review the objectives for their visits before they leave based on the the problems or needs found at the earlier visits.
10. A survey of the sites for prospective clinics should be made in order to have on hand a list of the minimum materials necessary for opening a family planning clinic in that location.

11. Training in management and administration is needed on all levels of the project, but especially for staff in Lomé. A change in the attitude toward management is also needed, as well as a clear system of accountability.
12. USAID should review its engagement in family planning activities in Togo. Especially critical for the continued progress of the project is the selection of the contractor. The selection criteria should include a review of the contractor's ability to provide the technical assistance and management support needed for the project at this time.

GENERAL REMARKS

The project clearly fills a need in Togo. Even though most couples who currently use family planning services would have used contraceptives anyway, the project provides a start and a legitimacy to family planning activities which it could not have achieved solely with the efforts of ATBEF. The IEC activities planned for the project should also bring to the clinics women who would otherwise not have considered using contraceptives.

The introduction of family planning in Togo did not have a smooth start. But by now it has gathered enough momentum that even if external support were withdrawn it would probably continue. An expansion in the program, however, is not possible without external support.

The government in Togo has basically taken a wait-and-see attitude regarding the program. Unless GOT is urged to do so by outside forces and unless external support is available, program activities will not expand.

Any external support would have to provide equipment for new centers and contraceptives and related materials to the family planning clinics. The TFHC also needs more support, especially in the form of technical assistance to improve training at the center.

Another issue is what type of expansion would be appropriate at this time. The government is tentatively committed to slowly providing a family planning clinic in the main town of each prefecture. The next logical step would be to continue opening new centers in the main towns in each subprefecture before entering into the rural areas. Whether such a policy can be established is difficult to say. If the GOT would be willing to allow auxiliary midwives to dispense contraceptives (i.e., spermicides and condoms) it would be possible to expand the services more quickly.

Apart from the government's reluctance to move quickly, the main limiting factor at this point is the training necessary for expansion of the program. With the current pace of training, the government can easily defend its attitude. At the same time, to rapidly train personnel at this time would be problematic. The TFHC does not have the capabilities to quickly train all midwives and physicians in IUD insertion (mainly due to the lack of acceptors in Lomé). Thus a more rapid expansion would require that family planning services be provided without the IUD being available as an option in some areas.

To rapidly train personnel for IEC activities may also lead to a situation in which the demand exceeds the supply of service delivery personnel. Thus, at this time it may be advisable to continue with the current training schedule.

However, it would be possible (if money for per diem and other course expenses were available) to increase the number of courses at the

center, since there are three facilitators and courses could run concurrently. Another way of expanding the program training would be to train regional trainers who could be responsible for training IEC personnel. Any training expansion, however, would require a more definite commitment from GOT to family planning.

The commitment to improving family health seems to be fairly strong in Togo. The project director sees family planning as a step in this process and is in his own way committed to increasing the services. The insistence from the external funding agencies (especially FPIA) to see the project as a family planning rather than family health project has, however, caused some concern among project personnel. A less clearly stated focus on family planning without losing sight of the ultimate goals would improve their commitment to the project.

Training in other family health aspects have been neglected within the project. Mainly, this is due to the fact that project personnel has not been able to include them in the curricula, due to the need to train personnel in family planning. But it is also due to a feeling that training in these subjects would not be approved by the funding agencies.

To more effectively use the facilitators at TFHC courses in other subjects could be given. For example, there is no reason why the health education training in water and sanitation, or in the vaccination program could not be included in the TFHC course schedule. This is perhaps an organizational question which could be resolved by discussions.

Coordinating all primary health care training through the TFHC would at the same time better utilize the resources available at the center and resolve the issue of how to integrate all primary health care activities at the health center level. Ultimately, as family planning becomes part of the

activities at the dispensary level, it has to be integrated with on-going work there, and the staff has to learn how to organize their activities in a way which does not leave anything out. At this time, new activities are added to the duties of health personnel without considering how the staff will be able to carry out all the required tasks.

To improve the effectiveness of family planning activities it is also necessary to strictly define what is expected from the USAID contractor who provides external support services. The requirements for technical and managerial support have not been well met in the current project. Expansion, or even continuation at the current level would require a closer look at this aspect of project management.

The current project personnel has relied heavily on the support given from ATBEF. The clinical training for midwives is totally dependent on the use of the ATBEF clinic. Without ATBEF's cooperation IUD insertion could not be taught at the TFHC. Similarly, clinical services could not have been provided without ATBEF supplying the contraceptives to the different clinics. This cooperation should be encouraged and maybe expanded. It may be possible to rely on ATBEF to provide support to IEC activities outside Lomé through its regional offices. Other avenues for cooperation should also be explored.

Even though activities so far have not given extraordinary results, there are signs that point to increasingly better results with a continued commitment by USAID to support the activities of the TFHC.

FINAL EVALUATION
TOGO FAMILY HEALTH
23 November - 20 December, 1985

FINAL REPORT

APPENDICES

submitted by:

Dr. Sif Ericsson
Dr Liliane Toumi

January 24, 1986

APPENDIX 1

OBJECTIVES FOR PHYSICIAN AND MIDWIFE COURSES

MODULE 1: Organization of personal work and group dynamics.

1. Read and develop summaries of the reading materials.
2. Identify group processes, group roles, group tasks and communication problems.

MODULE 2: Carry out family planning activities.

1. Give appropriate services to people who ask for family planning.
2. Assist people in resolving infertility problems.
3. Give nutritional information and advice.
4. Give advice regarding personal, food and environmental hygiene.

MODULE 3: Manage family planning programs.

1. Identify their own management responsibilities.
2. Describe the demographic characteristics of Togo.
3. Participate as a team member evaluating the health status of a community and determining which activities to undertake.

MODULE 4: Train health center personnel to work in a family planning team.

1. Participate in the planning of a training program for family planning personnel.
2. Carry out a training program (alone or as part of a team) which has been planned either centrally or regionally.

APPENDIX 1 (page 2)

CLINICAL TRAINING:

1. Interview ten acceptors supervised by the clinical trainer.
2. Examine ten new acceptors supervised by the clinical trainer.
3. Assist ten acceptors in selecting a contraceptive method.
4. Carry out the following:
Insert 3 IUDs; demonstrate the use of a diaphragm; explain the use of the pill, spermicides and condoms, each to 3 couples, and instruct in the use of natural methods.
5. Examine and counsel different types of acceptors who return for follow-up: 5 IUD, 1 diaphragm, 2 pill, 5 spermicide, 5 condom and 2 users of natural methods.
6. Examine at least 2 couples with infertility problems.
7. Fill out 20 FPIA forms.

APPENDIX 2

OBJECTIVES FOR NURSE AND SOCIAL WORKER COURSES

MODULE 1: Organization of personal work and group dynamics.

1. Read and develop summaries of the reading materials.
2. Identify group processes, group roles, group tasks and communication problems.

MODULE 2: General information in family planning.

1. Describe the demographic characteristics of Togo.
2. Give an operational definition of family planning.
3. Assist people in resolving infertility problems as part of a team.
4. Assist the community in resolving problems with family economics.

MODULE 3: Elaborate an IEC project in family planning.

1. Participate as a team member planning an IEC project in family planning.
2. Establish a plan for resolving identified family health problems.

MODULE 4: Carry out an IEC project in family planning.

1. Improve communication between the community and the health center personnel.
2. Prepare written or oral family planning messages which are appropriate for the intended audience.
3. Conduct an IEC session.

APPENDIX 2, page 2

MODULE 5: Plan a training program.

1. Participate as a team member planning a training program.

CLINICAL TRAINING:

1. Conduct an interview with an acceptor.
2. Conduct a health education meeting in family planning.

APPENDIX 3

COURSE SCHEDULE (number of days)

MODULE	DOCTORS	MIDWIVES	NURSES	SOCIAL WORKERS
Adm; opening	1	1	1	1
Work methods	3	3	4 ⁶	4 ⁶
Fam. Plan.	6 ²	15 ⁵	5	- 7
Manage FP ¹	9 ³	8	8	10 ⁷
Training	6 ⁴	5 ⁴	2	2
IEC activites	-	-	6	4
Review	2	2	3	2
Total	27	34	29	23

¹ Module requires 1 field trip

² Includes 2 simulation and 3 clinic sessions

³ Includes 3 clinic sessions

⁴ Includes 2 microteaching sessions for doctors; 1 for midwives

⁵ Includes 2 simulation and 12 clinic sessions

⁶ Includes a roleplay

⁷ Two modules combined

APPENDIX 4

NUMBER OF ACCEPTORS

CLINIC	NEO SAMP	IUD	CONDOM	PILL	EMKO
Zongo ¹	194	139	46	5	2
Tokoin ²	105	81	42	4	-
Bé ³	94	75	13	4	-
ATBEF ⁴	447	242	87	9	30
Total Lomé	840	537	188	22	32
Dapaon ⁵	48	11	17	1	-
Kara ⁶	37	68	30	12	-
Sokodé ⁵	53	29	9	20	-
Atakpamé ⁵	16	18	4	-	-
Total Regional	154	126	60	33	0
TOTAL	994	663	248	55	32

¹ October 83 to July 85

² January 84 to July 85

³ June 84 to July 85

⁴ October 83 to July 85; acceptors counted only during clinical training

⁵ March 85 to June 85

⁶ February 85 to June 85

55

APPENDIX 5

O.M.S./CFSP/LOME

Cours de Santé Familiale

Centre de :

Date :

Nom et Prénoms du responsable :

Nom et Prénoms du Stagiaire

Evaluation de stage pratique en Clinique

Eléments	Non fait	Fait avec erreur plus conséquences grave	Fait avec erreur sans conséquences grave	Fait sans erreur	Observations
Préparation de la Salle					
Accueil					
Entretien					
Examen physique et Clinique					
Examen gynécologique					
Mise en place du DIU					
Contrôle et retrait du DIU					
Autres méthodes					
TOTAL					

Signature de la Responsable, *h*

APPENDIX 6

LIST OF TRAINEES

CLINIC	NAME	TITLE	SERVICE	COURSE
MARITIME REGION				
Préfecture du Golfe (Lomé)				
CHU	Nomessi, Kodjo ¹	doctor ²	Gynecology	3
	Ayassor, Massiwa	midwife	Maternity	5
	Balebako, Kana	midwife	Maternity	4
	Kohoey, Atsoupi	midwife	Maternity	5
	da Sylveria, Akouvi	midwife	Maternity	4
	Akoutou, Ablavi	midwife	Maternity	5
	Agba, Akouvi	midwife ³	Maternity	5
	Agbodjan, Akoélé	nurse	Male Medecin	2
	Awidjolo, Afoua	nurse	??	7
	Divo, Adjoa	nurse	??	7
	Kekeh, Tassi Kanko	social worker	Social Services	6
Centre de Santé de Lomé	Komlan, Atayi ¹	doctor	Consultation	3
	Dandjoa, Ya Mayi	midwife ²	PMI	1
	Amegandjin, Kossiwa	midwife	PMI	5
	Ahiany, Amévi	midwife	PMI	4
	Agbodji, Adakou	midwife	PMI	5
	Langueh, Iradatou	midwife ³	PMI	4
	Looky, Piwenewe	nurse ³	??	2
	Adekplovi, Ayoko	social worker	Social Services	6
Centre de Santé de Bé	Bataba, Pilezza ¹	doctor	Consultation	3
	Attoh-Mensah, Akuavi	midwife ²	PMI	1
	Hekanou, Adjetse	midwife	PMI	5
	Foadey, Afiwavi Sika	midwife	PMI	4
	Akogo, Salamatou	midwife	PMI	5
	Kolagbe, Adakou	midwife ³	PMI	4

APPENDIX 6 (page 2)

CLINIC	NAME	TITLE	SERVICE	COURSE
MARITIME REGION				
Préfecture du Golfe (Lomé)				
Centre				
Social et PMI de Casablanca	Salami, Ayoaté Moustapha, Davi Zinsou, Afiwa	midwife ⁴ midwife social worker	PMI PMI Social Services	4 5 6
<hr/>				
Dir. de la Division des PMI	Johnson, Kafui Hounza, Noelie ⁵	midwife ⁴ midwife	Dir. de la Division des PMI	4 5
<hr/>				
C.C. de Tokoin	Bakou, Anyohalé Ouro-Bang'na, Nassara	midwife ^{2.4} social worker	PMI Social Services	1 6
<hr/>				
Med. Scol.	Tafamba-Dabou, Napo ¹	doctor	Consultation	3
<hr/>				
C. Social de Zongo	Aboussa, Adjoa	midwife	PMI	5
<hr/>				
Service Social de Lomé	Laban, Fafavi Lawson, Ablanyo Ayayi, Adakou Dogboe, Afi Lemou-Kpohou, B. ¹ Tchalla, Tanté	social worker social worker social worker social worker social worker social worker	Family and Child M.P.T., Lomé Social Services Dir. Reg. M.A.S C.C.Adjangakomé	6 6 6 6 6 6

APPENDIX 6 (page 3)

CLINIC	NAME	TITLE	SERVICE	COURSE
Préfecture des LACs				
Hôpital Aného	A Djeri, Amoye	midwife	Maternity	5
	Pinto, Kouamba	nurse	??	2
Polycli- nique Aného	Kpegba, Komi ¹	doctor	Med. Chef	3
	Akouete, Akué	midwife	PMI	1
Préfecture de VO				
C.S. de Vogan	Kponton, Aliba	nurse	Hôpital Vogan	2
	Boko, Afoua	nurse	??	7
Préfecture de YOTO				
Hôpital de Tagbligbo	Nabiliou, Komian ¹	doctor ²	Med. Chef	3
	Clocuh, Dédé Anissah	midwife	Maternity	1
	Lawson-Helluh, Akoko	nurse	Ward	2
Préfecture de ZIO				
Hôpital de Tsévie	Ouagbe, Dédé	midwife	Maternity	5
	Guinhouya, Adjoa	nurse	Ped. Ward	2
	Katawa, N'Déga	nurse	??	7
	Meliga, Ladi	nurse	??	7
Polycli- nique de Tsévie	Badakpou, Ayélé	midwife	PMI	5

APPENDIX 6 (page 4)

CLINIC	NAME	TITLE	SERVICE	COURSE
REGION DE PLATEAUX				
Préfecture de l'OGOU				
Polycli- nique de Atakpamé	d'Almeida, Kekoe	midwife	PMI	1
Aff.Soc. Atakpamé	Ketoglo, Yao ¹	social worker	Dir. Reg.	6
C. Hôpital Regionale Atakpamé	Adjiba, Nassan	midwife	Maternity	5
	Gandi, Akouavi	midwife	Maternity	4
	Pali, Essoyomewe	nurse	Surgical Ward	2
	Sokpo, Viwalo	nurse	Ped. Ward	2
	Todom, Hodalo	nurse	??	7
	Adjalle, Essiepe	nurse	??	7
Préfecture de HAHO				
Sub Div Notsé	Wodako, Kafui	midwife	Maternity	4
	Edorh, Edémessi	midwife ³	??	4
	Nibombe-Wake, Nounfo	nurse	Consultation	2
	Sadjo, Hétsu	nurse	??	7
Préfecture de KLOTO				
Sub Div. Kpalimé	Bassuka, Kuyawa ¹	doctor	Med. Chef	3

APPENDIX 6 (page 5)

CLINIC	NAME	TITLE	SERVICE	COURSE
Préfecture de KLOTO				
Hôpital de Kpalimé	Segbor, Akossiwa	midwife	Maternity	5
	Gbadam, Afiwa	midwife	Maternity	5
	Sant'Anna, Ayélé	midwife	Maternity	4
	Maouignon, Gninatin	nurse	Ward	2
	Akoessihoun, Amouvi	nurse	??	7
	Kpodar, Adama	nurse	??	7
	Yerima, Zaratou	nurse	retired	1
Préfecture d'AMOU				
Sub Div.	Anani, Akoua	nurse	Hopital Amlame	2
Préfecture de WAWA				
Sub Div.	Kpognon, Eya Djifa	midwife	Maternity, Badou	4
REGION CENTRALE				
Préfecture de SOTOUBOUA				
Sub Div.	Dossou, Mensah ¹	doctor ²	Med. Chef	3
	Boma, Bassanté	midwife	Maternity	4
	Arregba, Akaméhao	nurse	Hospital	2
Soc. Serv.	Tcheouafei, Ekpao ¹	social worker	Social Services	6

APPENDIX 6 (page 6)

CLINIC	NAME	TITLE	SERVICE	COURSE
Préfecture de TCHAOUDJO				
Polyclinique de Sokodé	Gnon-Manley, Rabi	midwife ²	PMI	1
	Adanto, Adatui	nurse	PMI	2
C. Hôpital Regional de Sokode	Tidjani, Amisséto	midwife	Maternity	5
	Payode, Tilatou	midwife	Maternity	5
	Makagni, Adja	midwife ²	Maternity	4
	Kouak, Gunthanti	nurse	Pediatrics	2
	Mensah, Akoko	nurse ³	??	2
	Soo, Tchilabo	nurse	??	7
Social Services Sokode	Koffi, Y. Houévo	social worker	Dir Reg	6
	Bodjana	social worker	Dir Reg	6
	Agba, Kossiwa	social worker ³	??	6
	Agba, Akoloum	social worker ³	??	6
REGION DE LA KARA				
Préfecture de la KOZAH				
C. Hôpital Regional de Kara	Kpinsaga, Djarba ¹	doctor ³	Medicin	3
	Birrega, Banibé	midwife	Maternity	4
	Bafai, Batélora	midwife	Maternity	5
	Kaga, Tchipéda	midwife ³	Maternity	4
	Bonfon, Sebina	nurse	??	7
	Plinga, Métédé	nurse	??	7
	Logossou, Akouvi	nurse	Surgery	2
Sub Div. Kara	Dogbe, Adjoa	midwife	PMI	1
	Beka, Zalia	midwife	Mat. Kouméa	4

APPENDIX 6 (page 7)

CLINIC	NAME	TITLE	SERVICE	COURSE
Préfecture de la KOZAH				
Social Services Kara	Bini, Prewé Todjala, N'Bao ¹	social worker social worker	Social Services Dir. Reg.	6 6
Pro. Soc.	Nimon, Baloukina ¹	social worker	Proj. Fem. Landa	6
Préfecture de BINAH				
Sub Div.	Folly, Adjoa	nurse	Pagouda	2
Préfecture d'ASSOLI				
	Borokom, Pozopendou	nurse	Hôp. Bafilo	2
Préfecture de BASSAR				
Sub.Div.	Jibidar, Ayité ¹ Alfa, Bérézam	doctor nurse	Hôp. Bassar Hôp. Bassar	3 2
Soc. Serv.	Ali, Lidao	social worker	Social Services	6
Préfecture de DOUFELGOU				
Sub.Div.	Djagbassou, Yoka ¹ Tabiou, Mawaté Johnson, Ablanban Ayawovi, Akuwavi	doctor midwife midwife ³ nurse	Hôp. Niamtougou Hôp. Niamtougou Hôp. Niamtougou Hôp. Niamtougou	3 4 4 2

APPENDIX 6 (page 8)

CLINIC	NAME	TITLE	SERVICE	COURSE
Préfecture de la KERAN				
Sub.Div.	Djanaye, Adja	midwife	Project	4
	Kinvi Kokoe	midwife	Hôp. Kandé	1

REGION DES SAVANES Préfecture de l'OTI

Sub.Div.	Torsoo, Akoussah	midwife	Hôp. Mango	4
	Sekou-Hlontchi, Améyo	nurse	Hôp. Mango	2

Préfecture de TONE

C. Hôp.Reg.	Djadja, Dédé	midwife	Maternity	5
Dapaon	Tchandao, Oialo	midwife ³	Maternity	4
	Katadra, N'ta Libani	nurse	??	7

Social Services	Thangana, Ekpao	social worker ³	??	6
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1 male

3 transferred from other place

2 has been trained abroad

4 medical assistant

5 now working as clinical coordinator for the FPIA project

APPENDIX 7

CLINIC 2

LIST OF MATERIALS NEEDED (21 clinics)

Table gynécologique	14
Lampe sur pied	19
Ampoul de rechange	20
Armoire	21
Stérilisateur à la chaleur sèche	16
Poisionniere électrique	22
Kit d'insertion (IUD)	10
Kit de retrait (IUD)	10
Ventilateur	25
Pèse personne	21
Flannell	50 (ou 50 squ. m.)
Boite à instrument	21
Plateaux inox gd 35+25	38
Plateau inox moyen 26+18	38
Bsssin haricot	42
Tambour 24+5	21

65

APPENDIX 8

TABLE 1

CHOICE OF METHOD (8 clinics)

Method	Lomé(4)	Regional(4)	Total
Neosampon	51.88%	41.29%	49.90%
IUDs	33.17%	33.78%	33.28%
Condoms	7.91%	16.09%	12.45%
Pills	1.36%	8.85%	2.76%
EMKO	1.98%	0.00%	1.61%
Total number of acceptors	1619	373	1992

APPENDIX 9

TABLE 2

NUMBER OF CHILDREN AND USE OF CONTRACEPTIVES

(273 women in Bê)

No. Children	No. Women	% Women	Cu.m. %
0	1	.36	.36
1	35	12.82	13.18
2	75	27.47	40.65
3	34	12.45	53.10
4	38	13.92	67.02
5	25	9.16	76.18
6	19	6.96	83.14
7	33	12.09	95.23
8	8	2.93	98.16
9	3	1.10	99.26
10	1	.36	99.62
12	1	.36	99.98

APPENDIX 10

LIST OF IEC MATERIALS NEEDED¹

KIND	SOKODE	ATAKPAME	KARA	KPALIME	NOTSE	TSIEVE
Posters	X	X	X	X	X	X
Diapositives	X	X	X	X	X	X
Slide projector	X	X	X	X	X	X
"Spot"	X	X	X	X	X	X
Drawings	X	X		X	X	X
Anatomy drawings		X	X	X		
Flipbook (IPPF)	X	X				X
Films		X		X	X	
Film projector		X		X	X	
Flannelograph	X				X	X
Documents				X		X
Transport	X					

¹ This list is based on responses to a survey carried out by Mrs. Kankarti.