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## Trip Report

# 0-172

**Travelers:** Ms. Lynn Knauff, INTRAH Deputy Director  
Mr. Pape Gaye, INTRAH/WCA Director  
Ms. Terry Mirabito, INTRAH Program Officer

**Country Visited:** TOGO

**Date of Trip:** June 4 - 19, 1987

**Purpose:** To conduct a Training Needs Assessment

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- G . UNFPA Liste des Projets
- \*H. CDC/JSI Contraceptive Product Distribution Survey

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\* On file at INTRAH

### LIST OF ABBREVIATIONS

<b>APEL</b>	Arrivée du Prochain Enfant à Lomé (Arrival of the Next Child in Lomé -- Survey project conducted by URD).
<b>APS</b>	Agent pour la Promotion Sociale
<b>Assistants Sociaux</b>	Social Assistants
<b>ATBEF</b>	Association Togolaise pour le Bien - Etre Familiale (an IPPF affiliate)
<b>BAC</b>	Baccalaureat (end of high school diploma)
<b>BEPC</b>	Brevet d'Etudes du premier Cycle (mid high school diploma)
<b>CHU</b>	Centre Hôpital Universitaire (Lomé)
<b>DG</b>	Director-General (Directeur Général)
<b>FHTC</b>	Family Health Training Center
<b>FPIA</b>	Family Planning International Assistance
<b>GOT</b>	Government of Togo
<b>IPPF</b>	International Planned Parenthood Federation
<b>KAP</b>	Knowledge/Attitudes/Practice Study or Survey
<b>Lycée</b>	High School
<b>OMS</b>	World Health Organization
<b>PCS</b>	Population Communication Services
<b>PMI</b>	Maternal and Child Health
<b>PNBEF</b>	Programme National de Bien - Etre Familial
<b>RAPID</b>	Resources for Awareness of Population Impacts on Development
<b>RHU</b>	Regional Hospital
<b>sage femme</b>	midwife

<b>sensibilisation</b>	a particular kind of activity, or series of activities, to develop client awareness and acceptance of family planning
<b>UNDP</b>	United Nations Development Project
<b>UNFPA</b>	United Nations Fund for Population Activities
<b>URD</b>	Unité de Recherche Démographique

EXECUTIVE SUMMARY

At the request of REDSO/WCA, an INTRAH team conducted a training needs assessment in Togo from June 4 to June 19, 1987. The team members were: Lynn Knauff, Deputy Director and Pape Gaye, Regional Director for Francophone Africa; and Terry Mirabito, Program Officer, who assessed clinical training needs from June 3 to June 12.

The assessment provided background information in preparation for INTRAH's participation in the Family Health Initiatives II project in Togo, for which REDSO/WCA will provide INTRAH with a \$200,000 buy-in for technical assistance during the three-year project.

Field visits were made to nine clinic sites in four of five economic regions, discussions were held with about 50 persons from public and private sector organizations and donor assistance agencies, pertinent documents were reviewed, and a tentative strategy for INTRAH involvement was developed, discussed with, and agreed to by USAID/Lomé, the Director-General of the Ministry of Health, ATBEF, the Director of Maternal Child Health, and the International Planned Parenthood Federation regional office.

The next INTRAH visit is planned for September 1987 during which the first steps of the INTRAH strategy will be taken.

The INTRAH team expresses appreciation to the governmental and non-governmental officials who gave generously of their time during interviews and meetings, and to USAID/Lomé for the assistance and guidance provided to the team.

SCHEDULE OF ACTIVITIES

- June 3 INTRAH team arrived in Lomé from Abidjan at 5:15 p.m.
- June 4 Briefing at USAID/Lomé with Development Officer Mr. Ernie Popp and Ms. Caroline Karoma, Family Planning Project Coordinator.
- Meeting with Director-General for Public Health, Dr. Tognide Houenassou-Houangbe, Ministry of Health
- Meeting with Mr. Joe Naimoli, Peace Corps Volunteer assigned to Health Education Division of the Ministry of Health
- June 5 Meeting with Dr. Ayite D'Almeida, Coordinator of Studies, World Health Organization Training Center.
- Meeting at ATBEF with Mr. Kwasi Mensah, Executive Director, and with Ms. Enyonam Mensah, Clinical Director.
- Meeting with Senior Program Officer Mr. Alpha Diallo, and Mr. Joseph Karoma and Dr. Mwomba, Program Officers, International Planned Parenthood Federation.
- June 8 Meeting at USAID/Lomé.
- Meeting at the Maternal Child Health office with Ms. N. Hounzah, Clinical Coordinator.
- Meeting with Mr. Ahoulou, Head of Nursing Services/Ministry of Health, at the World Health Organization Training Center.
- June 9 (Ms. Mirabito, Ms. Karoma and Ms. Hounzah left for field trip to Kara and Sokodé).
- Meeting with Dr. Tchasselu Karsa, Head, Epidemiology Division, Ministry of Health.
- Meeting with Mr. Komlan Fongbemi, Director of Production, at Togopharma.
- Meeting at the Maternal Child Health office with Dr. Vignon Devo, Maternal Child Health Director, Ministry of Health.

Schedule of Activities (Cont.)

**June 9 (cont.)** Meeting with Mr. Kouami Houngez, Health Planner, Ministry of Planning

Meeting with Mr. Yaouvi Fanidji, Assistant for Program and Finance, United Nations Fund for Population Activities.

**June 10** Meeting with Mr. Peter Delahaye, Resident Representative, UNICEF.

Meeting at the Maternal Child Health office with Dr. Devo.

Meeting at USAID/Lomé with Mr. Popp.

Meeting with Ms. Marja Janssens, Demographer, UNICEF.

(Ms. Mirabito and Ms. Karoma returned from field trip).

**June 11** Mr. Gaye, Ms. Knauff and Ms. Hounzah visited Atakpamé and Kpalimé.

**June 12** Meeting at USAID/Lomé.

Meeting with Dr. Devo and Dr. D'Almeida at the World Health Organization Training Center.

Meeting with Dr. Devo, Ms. Hounzah, Ms. Tetcou, Mr. Memen and Ms. Ayassou at the World Health Organization Training Center.

Meeting with Mr. Ahoulou at the World Health Organization Training Center

**June 13** Ms. Mirabito departed for the US.

**June 15** Meeting at USAID/Lomé.

Meeting with Dr. Assimadi, Head of Pediatrics and Principal of the Midwifery Training School, Centre Hôpital Universitaire.

Meeting with Dr. Devo and Mrs. Hounzah at the World Health Organization Training Center.

Schedule of Activities (Cont.)

- June 16** Meeting with the Research Team of the Demographic Research Unit (URD) at the URD office.
- Meeting with Mr. Louis O'Brien, Technical Advisor to the USAID Water and Sanitation Project.
- June 17** Meeting with Ms. Adjoa Womas, Director of Training, and Ms. Degbou, Director of the Social Center in Lomé, Directorate of Social Affairs.
- Meeting at USAID/Lomé.
- June 18** Meeting with Dr. Hodonou, Professor of OB/GYN, Centre Hôpital Universitaire.
- Debriefing meeting with Mr. Karoma and Ms. Santos at International Planned Parenthood Federation.
- Debriefing meeting with Mr. Mensah, Ms. Mensah, and Mr. Leyno Kpédji Mathe at ATBEF.
- Debriefing meeting with Dr. Houenassou.
- Meetings at USAID/Lomé.
- June 19** Debriefing with Dr. Devo and Ms. Hounzah at the World Health Organization Training Center.
- Debriefing at USAID/Lomé with Mr. Popp, Acting Director Ms. Barbara Howard, and Ms. Karoma.
- Mr. Gaye departed for Abidjan at 9:00 p.m.
- June 20** Ms. Knauff departed for the U.S. at 6:30 a.m.

I. PURPOSE OF TRIP

The purpose of the trip was to assess training needs and included the following objectives:

- A. Assess the capability and capacity of the Family Health Training Center (FHTC).
- B. Identify in-country needs for clinical and non-clinical training.
- C. Assess possibilities for INTRAH collaboration with the WHO Training Center in providing regional training.
- D. Assess potential for collaboration with ATBEF in providing clinical training.
- E. Learn about the FPIA-supported project of the PNBEF, which had as a major objective the training of 170 medical and paramedical professionals and 50 social workers in family health/family planning during the period October 1983 - November 1986.
- F. Learn about the plans of UNFPA and UNICEF for support of the PNBEF maternal and child health services.

II. ACCOMPLISHMENTS

- A. The team visited a total of nine service points in four of the country's five economic regions. The Savane region in the far north was the only region not visited.
- B. Briefings and debriefings were held with the Director-General of the Ministry of Health, USAID, ATBEF, IPPF, and the Director of MCH.
- C. Meetings and work sessions were conducted with the Director of MCH, the WHO Coordinator of Studies, the newly-recruited USAID Population Program Coordinator, and the training staff of the WHO Training Center.
- D. The curricula used during training of Health and Social Affairs personnel in family health during the FPIA project were reviewed.

- E. A meeting was held with the staff of the Unité de Recherche Demographique (URD) of the University. Potential areas for study were identified and collaboration with other agencies was discussed.
- F. Pre-service and in-service training of health and social workers was discussed with heads and/or staff of professional schools and government units.
- G. Meetings were held with donors involved in MCH/FP, including UNICEF, UNFPA, WHO, and IPPF.
- H. Discussions were held with the Health Sector Specialist in the Ministry of Planning on coordination of donor activities and long term plans for MCH/FP program support.
- I. A multi-phase program and training development strategy was proposed by the team and submitted to the MOH and USAID for their consideration.
- J. Recommendations were made for the next steps of INTRAH participation in strategy implementation.

### III. BACKGROUND

The current visit was the second for INTRAH in PAC II and was undertaken at the request of REDSO/WCA, preliminary to implementation of the FHI-II project in Togo. INTRAH's participation in that project will be directed toward training development in the public sector.

In PAC I during July - September 1983 INTRAH financed the consultation of Dr. George Walter of IHP/Santa Cruz to work with the PNBEF director and training team in preparing to implement an FPIA-supported training project. The training was to take place at the newly-constructed USAID-financed Family Health Training Center (FHTC), attached to the WHO regional training center. Dr. Walter and the team developed a training strategy and training management plan, training objectives, course curricula and materials and standards for clinical competence, and established the post training

functions of the three types of personnel to be trained. Dr. Walter's assessment was that the project had great potential for success, that the staff involved in training was very good, and that the Family Health Training Center facility and materials developed were outstanding.

At the beginning of PAC II USAID requested that INTRAH develop a proposal for a comprehensive approach to strengthening training conducted by the FHTC staff. The request called for revision of the Center's training plan to better integrate training activities with the bilateral project service delivery strategy.

In March 1985 Dr. George Walter again visited Togo and consulted with USAID representatives, the MOH, the FHTC staff and the ATBEF. Objectives of that visit were to conduct a follow-up of his technical assistance to the FHTC staff and to identify possibilities for collaboration between the project and INTRAH. The visit revealed serious communication problems among agencies involved in MCH/FP in Togo. At that time, there were uncertainties about the future since the bilateral project, the FPIA project and UNFPA support were coming to an end. Subsequently the FPIA contract was extended and a new FHI-II sub-project prepared.

#### IV. DESCRIPTION OF ACTIVITIES

##### USAID

The INTRAH team met with USAID Development Officer Mr. Ernie Popp and with the newly-hired USAID Family Planning Project Coordinator Ms. Caroline Karoma for briefing and debriefing and for six update and planning sessions during the visit. The team prepared a mid-visit report and a final summary report (see Appendix B) for Mr. Popp.

At the briefing, the team was told that the Ministry of Health had signed the FHI-II Project grant agreement, and was furnished with a copy. The conditions precedent section was of particular interest to the INTRAH team: a management audit of the MOH was required before Project funds could be transferred to the MOH. It was estimated that the process for releasing funds could take up to three months thereby slowing-down project implementation. Under terms of the agreement, the Ministry will provide three Project coordinators and transportation for them. Currently, the coordinators (who were coordinators under the FPIA project) are employed in other positions but, as far as is known, could be re-assembled for this project.

The team learned that the UNFPA and World Bank were possible donors on behalf of population and family planning activities. However, the UNFPA had not yet received a project proposal from the government, and the World Bank was still formulating its project (which will include rehabilitation of MCH centers).

Mr. Popp felt that there was not much family planning service activity or demand, although the President of Togo had stated an interest in increasing the government's involvement in family planning and the President of the General Assembly had, reportedly, congratulated ATBEF on its program. Within the Ministry of Health, however, Mr. Popp felt that interest was low and that the national program was not effective.

Ms. Caroline Karoma, the newly-hired Project Coordinator, accompanied the team on many of the visits to governmental and non-governmental officials, and traveled with Ms. Mirabito and Ms. Hounzah to Kara and Sokodé to review the status of clinics and clinical services. Ms. Karoma is on a personal services contract for three years

and will have an office in the FHTC portion of the WHO Training Center. It is expected that she will work under Mr. Popp's direction as the USAID monitor for the project, representing USAID and handling other population/family planning matters for the Mission on behalf of Mr. Popp. Other than Ms. Karoma, there was no one else in the USAID Mission with population/family planning program experience.

At the team's debriefing session, Mr. Popp and Ms. Howard endorsed INTRAH's recommendations as set forth in the summary report (see Appendix B). Discussion was also held on the probable funding schedule and the initiation of project activities in addition to those which will be assisted by INTRAH. Ms. Karoma will begin to plan for clinic inventories so that once funds are released, teams can travel to clinic sites with a standard inventory questionnaire. At that time, the teams will also gather information about training needs in contraceptive update. The next INTRAH visit was planned for September, which is also the time for another RAPID presentation.

A PCS staff member was scheduled to arrive during the week following the departure of the INTRAH team, and will be furnished with a copy of INTRAH's summary report.

Ministry of Health, Social Affairs and Women's Condition

The Ministry is headed by a physician, with directors-general for each element (see Appendix C for the MOH organogram). The INTRAH team focused mainly on the health element of the Ministry because the National Family Planning program (PNBEF) was a project of the Division of Maternal and Child Health, one of eight divisions, and health facilities of the Ministry dominate the family planning

service network. During the FHI-II project, INTRAH is expected to provide technical assistance in the public sector, primarily to the MCH Division and the health services network.

#### Directorate of Health

The INTRAH team held two meetings with the Director-General of Public Health. His view was that family planning should be integrated with MCH and midwives should be the front-line of service delivery. In the second meeting with him, the INTRAH team debriefed him on their findings and recommendations. He supported the idea of developing a prefecture-level, geographically phased program based on findings from small-scale research (KAP) and results from investigation of the status of family planning clinical services and needs for training.

In meetings with Dr. Devo, MCH Director and Director of the PNBEF, he observed that the national program was theoretically in place, although resources did not permit operation of a national program. For the past six months a UNFPA consultant had been working in his office to evaluate the program and make recommendations to UNFPA for possible assistance.

The Programme National de Bien - Etre Familial (PNBEF), a project of the UNFPA, started in 1977 and ended in 1985. USAID supported the PNBEF through a bilateral project under which a training center was constructed. The center was referred to as the Family Health Training Center, but because it is physically attached to and administered and maintained by the WHO Training Center, it is considered part of the WHO center. USAID also supported the PNBEF through a contract with FPIA, which provided funds for training, two

vehicles, the salaries of three coordinators (one each for clinical, IEC and administration), and contraceptive equipment and supplies. The FPIA contract concluded in November 1986 when the last of twelve family health courses was in process at the FHTC.

During the FPIA-supported project, Dr. Devo had three coordinators under his direction (Ms. Hounzah, Ms. Kankarti, and Mr. Gnon-Manley), and space was set aside in the FHTC section of the WHO training center for them and for training. However, the three family health trainers were not under his direction. He reported that most of the training had been conducted by expert lecturers: physicians, other governmental consultants, and WHO Training Center staff. FPIA did not send trainers or consultants, but had sent evaluators. Dr. Devo felt that space in the WHO Training Center and re-grouping of the three coordinators were definite commitments to the new project by the Ministry. During the debriefing the INTRAH team shared their general and site visit observations and recommendations with him, and he agreed with all of them.

In a discussion with Dr. Karsa, Head of the Division of Epidemiology, Dr. Karsa reported observing a great deal of interest in family planning. He felt that when infant mortality is reduced, people will be more ready to limit their family size.

The team also met with Dr. Assimadi, Professor and Head of Pediatrics at the Central Hospital (CHU) in Lomé and Principal of the School of Midwifery, both of which are Ministry of Health facilities. The School of Midwifery closed in 1984, but Dr. Assimadi expected the school to re-open within two years time with a more community-oriented and problem-centered curriculum. He suggested that INTRAH might be of help in development of the new curriculum.

Dr. Assimadi is currently involved in UNICEF-assisted re-training of midwives which consisted of five-day regional courses. He reported that the midwives had requested an update in family health, and he was also interested in a stronger family planning program. It was his opinion that improvement in services and an increase in service points would result in an increased service demand. He felt that there is an interest in family planning which is not being expressed. Dr. Assimadi advised INTRAH to conduct regional needs assessments and to decentralize training based on common needs found within regions. He felt that integrating family planning with MCH would be easy.

Mr. Ahoulou, Head of Nursing Services (there is no Chief Nursing Officer position in the Ministry), met with the team twice. In response to the team's questions he provided the following information:

1. The Ministry has no Chief Nursing Officer. Although he is the Nursing Services Director, he spends only three months per year in his Ministry post and the rest of the time he is engaged in WHO regional training courses and with in-service training of nurses.
2. There are 228 physicians, 1200 nurses and 300 midwives in Togo.
3. There is one national hospital (CHU in Lomé), five regional hospitals, 21 prefecture-level hospitals, five rural hospitals and 350 dispensaries.
4. The duration of nursing and midwifery education is three years; auxiliary nursing and auxiliary midwifery is two years; and, medical assistants' education is three years for nurses and midwives with five years of experience. Medical education is of six years' duration.

5. Nurses serve in hospitals and village health centers; midwives serve in hospital maternities and MCH centers; auxiliary nurses serve in hospitals and dispensaries; auxiliary midwives serve in villages; and, medical assistants serve in rural hospitals.
6. Training needs assessments are conducted mainly by supervisors.
7. Currently, the three trainers formerly involved in family health training are assigned to WHO-sponsored training as follows: Ms. Memen and Mrs. Ayassou work with Mr. Erroll Williams, and Mrs. Tetou works with Dr. Kadjaka, the Deputy Coordinator of the WHO Training Center.

The INTRAH team also met with Dr. Hodonou, Professor and Head of OB/GYN at the national hospital. He is a former Director-General of Public Health and his particular interest is in infertility. He was involved in the FPIA-assisted family health training as a lecturer on contraceptive methods and infertility but was not involved in the clinical practicum because the national hospital was considered unsuitable for a practicum, having no specific hours or days for family planning services.

On the issue of resistance to family planning acceptance, Dr. Hodonou felt that a variety of factors were involved, but he did not think that laws and regulations were hindering factors. He noted that health personnel tackle what they know and are equipped and supplied to do: services are not provided if personnel do not have the knowledge and means to do so.

When asked about traditional child spacing methods (breastfeeding for one year and abstinence for two years), Dr. Hodonou felt that modernization was destroying this pattern in Togo. He noted that there were no studies to

support his view, and in general there was an absence of research studies. He did not conduct research himself, but felt that studies could and should be conducted, which would then form the basis for family health program development and for developing appropriate approaches to client awareness and recruitment.

#### Directorate of Social Affairs

The Directorate of Social Affairs and the Directorate for the Condition of Women are under the reorganized Ministry of Health, now the Ministry of Health, Social Affairs and Women's Condition. At the National level there is a Director General, Mr. Katey, who supervises six divisions, which are organized according to major programs: Community Development; Literacy and Adult Education; Protection of the Family and Children; Special Women's Program; Youth Protection; and Training Services, which also has responsibility for research. (The Directorate General for Women's Condition is viewed as being equal to the Directorate for Social Affairs, but it has only one division, the Division of Labor. At the regional level there is a Director in each of the five economic regions. The Regional Director supervises about 60 agents who are assigned at the prefecture, canton, or village level.)

An annual budget is allocated to Social Affairs, but barely covers the needs. Additional money is provided by foreign donors.

There are two categories of Social Affairs personnel, the Social Assistants (Assistants Sociaux), recruited at the BAC (end of Lyceé) level, and the Agents for Social Promotion (Agent pour la Promotion Sociale or APS), who are recruited at the BEPC (mid lyceé) level. Both groups are trained for three years, but Social Assistants supervise APSS.

The Social Assistants are trained in Abidjan, Dakar or France and to date, there are about 60 of them. The APSS are trained at the Social Assistant Training School in Togo, which was funded by UNDP and UNICEF until 1984 when it closed for lack of funds. Since 1967, about 500 APSS have graduated. In-service training in community program management is provided to APSS, but only on a very sporadic schedule, and the Division of Training has only one person trained in training techniques, Ms. Womas, the Director of Training. In general, however, the extent of in-service training provided is very limited.

The INTRAH team met with Ms. Womas and Ms. Debgau, Social Assistant Director for a Social Center in Lomé. Past training and needs for the future were discussed, focusing on the role of Social Affairs personnel in promoting MCH/FP services and sensibilisation.

In the 1970s under the PNBEF, Social Assistants and APSS from 10 Social Centers and four Specialized Services in Lomé were trained in order to inform the population about contraceptive methods. Between 1983 and 1986, under the FPIA project, an additional 45 Social Affairs personnel were trained. According to Ms. Womas, criteria used for selecting participants to receive training insured that the acquired skills would be applied because participants were selected from those working in Family Protection with organized groups, or in MCH clinics. According to Ms. Womas, skills are still being used, as the Ministry of Social Affairs serves an average of 2500 to 3000 young women each year in its centers. Many of these young women are mothers and adolescents seeking advice and/or information on family planning while taking lessons in home economics subjects.

Ministry of Planning

The INTRAH team met with Mr. Hounges, Health Planner in the Ministry of Planning, who holds a degree in public administration from Chico University in California. In response to the team's questions he furnished the following information:

1. 91% of the health budget was spent on salaries.
2. Budgeting is a centralized function: prefectures receive funds from the Ministries for programs and salaries.
3. The health plan cycle is for five years (1985 - 90); however, resources to fund the plan are not available to implement it.
4. World Bank and UNFPA are possible sources of assistance for population/family planning. A World Bank team visited in December 1986 (IHP Program Coordinator Jean de Malvinsky was one of the team members) and worked with a Togolese team, which did not include Dr. Devo. (Subsequently, the INTRAH team tried to obtain a copy of the World Bank's health sector and team reports, but was unsuccessful.)
5. World Bank established four areas for support: instructional support, rehabilitation and reinforcement of existing infrastructures, support of IEC in family planning, and establishment of a population unit in the Ministry of Planning.
6. The MCH Division of the MOH had no money and no power.
7. There are vacancies in health positions, but fiscal austerity measures prevent them from being filled and were the cause for closing the midwifery school and reducing intake in the medical school.
8. Monthly salary ranges for personnel were reported to be: nurse, 40,000 CFA; midwives, 70,000 CFA; medical assistants, 85,000 CFA; and, physicians between 90,000 and 100,000 CFA. (\$1 = 300 CFA).

Mr. Houngez said that ATBEF had good support from the population, but noted that the service delivery and uptake problems were in rural areas where ATBEF is not currently active.

#### WHO Training Center

The WHO Training Center is a Francophone regional training resource co-sponsored by WHO and the Government of Togo. There are three teaching faculty: Dr. D'Almeida (management, community health and training methodology), Dr. Kadjaka (community and public health), and Mr. Erroll Williams (health education). Togolese lecturers are used in specialty areas as needed. The three trainers who were formerly involved in family health training assist the teaching faculty in group facilitation and with logistics. The GOT pays the salaries of Dr. D'Almeida, Dr. Kadjaka and the three trainers; Mr. Williams' salary is paid by WHO.

The types of regional short courses offered by the center include: 1) a course for maintenance technicians; 2) a community health course; 3) training of trainers of primary health care workers; 4) health education; 5) a course for public health inspectors; and 6) courses in public health. The center is in a period of transition and will probably shift toward long-term training in management of community health programs for regional high-level participants and Togolese physicians, giving the Center both regional and national perspectives. The INTRAH team was told that eventually the WHO Training Center will offer courses in English. There is also a possibility that the WHO Center in Benin will be closed down and its responsibilities turned over to Lomé. Decisions about the future of both WHO centers were expected to be made in Brazzaville during the summer.

The INTRAH team met twice with Dr. D'Almeida, Director of Studies. During the second meeting, which Dr. Devo attended, the team was told that the Family Health Training Center (FHTC), which is physically attached to and used by the WHO during conduct of its courses had never existed as an entity separate from the WHO Training Center. Dr. D'Almeida described the FHTC building as part of the WHO Training Center which provided maintenance for it. He said that the FHTC building had been formally transferred by USAID to the MOH, which had given over its management to WHO. The family health courses supported by FPIA had been conducted in the building and the three FPIA-paid coordinators had offices in the building. Neither Dr. Devo nor Dr. D'Almeida foresaw any problem with continued use of the building for family health training and for office space for Ms. Karoma and the three coordinators if that was desired.

Another point made by Dr. D'Almeida was that he had had no direct communication from USAID on the INTRAH team visit; instead, he had a copy of a letter from Mr. Golden (former USAID/Lomé Director) to the Ministry which said the INTRAH team was making an evaluation visit. He was visibly disturbed, but seemed somewhat pacified by a second explanation of the visit, which was again described as a needs assessment based on expectations of INTRAH as described in the Project Paper and also in the grant agreement, a copy of which he had.

In a brief meeting with Mr. Erroll Williams (who had spent eight years in the center in Lomé and six years in the Benin center), he said that the center was in a transitional period and that course offerings were uncertain. He also

pointed out that Dr. D'Almeida (newly-appointed Dean of the Medical School) would be leaving on August 31, and that he (Erroll Williams) would be acting Coordinator until a replacement was found for Dr. D'Almeida.

### Togopharma

Togopharma is a parastatal company which has the monopoly on importation and distribution of pharmaceuticals.

Technically, Togopharma is under the Ministry of Health, but administratively it is under the jurisdiction of the Ministry of Industry and Parastatal Companies. Togopharma uses its own network of pharmacies and supply depots to distribute pharmaceuticals in the country. No major manufacturing of products is done locally.

There are 59 pharmacists in the country, 20 are employed by Togopharma and the rest are privately employed. All have been trained outside the country in Senegal (90%), the US, Canada, France and the Soviet Union.

The government trains pharmacist assistants of whom there are 79. Their educational background is BPEC and their training emphasizes the medicines required to treat common and endemic diseases.

The INTRAH team met with Mr. Komlan Fongbemi, Director of Production and Deputy Manager of Togopharma. He felt that pharmacists should have a role in the national family planning program in education and information about the benefits of family planning both for their clientele and their professional colleagues in allied fields. He felt that men in particular were an obstacle to ready acceptance of family planning by women. He encouraged the team to organize regional seminars for pharmacists, through the pharmacy associations, which should stress the importance of family planning to family health.

The team raised the issue of contraceptive availability in markets outside of governmental control. He said the government was opposed to the situation and trying to stop it.

With respect to importation of contraceptives through regular channels, pills, IUDs and condoms are imported and available through government and licensed outlets. (A joint CDC/JSI team visited Togo in January 1987 and did a survey of contraceptive product distribution. Their survey results (see Appendix H) indicate the difficulty experienced in collecting data on this subject).

The team asked Mr. Fongbemi if any other US-based FP agencies had been to talk with him and he replied that only the UN and World Bank had discussed pharmacists and family planning with him.

The Demographic Research Unit (URD) of  
the University of Benin

The Demographic Research Unit has been in existence since 1975 and is attached to the University of Benin in Lomé. The INTRAH team was introduced to the Unit by Ms. Marja Janssens, a demographer who has been associated with URD for over three years and is also a UNICEF consultant.

The team first met with Ms. Janssens at UNICEF and learned of two studies: one entitled "The Arrival of the Next Child in Togo" in which contraceptive use, child-spacing patterns and marital status were investigated; and, the second in progress and collaboration with Dr. Devo, MCH Director, a survey of market women and their customers on traditional and modern contraceptive availability and use, and the quality of contraceptive instruction and advice given by the market women.

Findings from the first study indicated common spacing intervals of 30 - 36 months which are achieved through breastfeeding and abstinence, but very little modern contraceptive use.

Early findings from the second study revealed that the market women gave grossly incorrect verbal instructions in use of the pill and are distributing expired products and products without patient inserts. Ms. Janssens felt that the government should change its policy on the need for husband's consent so that women could more easily go to reliable sources of contraceptive advice and products.

A second meeting was organized at the site of the Research Unit between the INTRAH team and six of the URD staff, including the Director, senior demographers and a geographer documentalist.

Over the years, URD received support from the Population Council, the Carolina Population Center of the University of North Carolina/Chapel Hill, UNFPA, and UNICEF. From 1975 to 1982, the unit was small and had only two persons and one room. With assistance from UNFPA it grew and started having a larger role in the promotion of demographic studies and teaching. Work accomplished in population and demography includes surveys on fertility in southeastern Togo, marriage and marriage rate (nuptialiatè) in Togo, and mortality and morbidity in persons hospitalized one to five years at Lomé Hospital. A study was currently being completed on socio-cultural factors and modern and traditional contraceptive methods in collaboration with Dr. Devo, MCH Director.

URD is equipped with three computers and a well-stocked library. It has potential for providing needed

research on some key aspects of MCH/FP to support the development of IEC messages. However, it is somewhat handicapped because there is no health person on the team. Furthermore, there is confusion on the part of the unit as to how to apply the results of their surveys and studies to operational problems and opportunities.

URD has experience in other activities, such as the organization of national and international workshops and conferences; for example, it has worked with UNFPA in organizing seminars on population issues for school teachers. URD has also collaborated with IDRC and the Ford Foundation on an international seminar on Adolescent Fertility in Africa. Staff members expressed their willingness and desire to contribute to efforts to study and develop the MCH/FP program.

#### ATBEF

ATBEF has been providing MCH services since 1976 and family planning services since 1983. The Association has a clinic on the premises, which was used for the clinical practicum during FPIA-assisted training. ATBEF also supplied contraceptives to MOH service points during the period of FPIA assistance.

The FHI-II grant agreement calls for ATBEF to provide services (including CBD), information and education (with assistance from PCS), and to continue distribution of contraceptive supplies to MOH service points. It is expected that the ATBEF program will function in collaboration with the public sector program. In this regard, ATBEF will be given Project funds for a laboratory in which the required tests preliminary to a contraceptive prescription will be conducted.

Ms. Mensah, the Clinical Director, had been a clinical preceptor during the training courses conducted under PNBEF/FPIA auspices. She observed that the practicum had been too short for the basic performance standards to be achieved, and that too many trainees were sent at one time, making the situation even worse. She felt that her clinic could handle one trainee per week.

With respect to ATBEF/PCS collaboration, since the last PCS visit in April 1986, no further contact by PCS was reported by Mr. Mensah, the Executive Director. However, Ms. Karoma informed him during our meeting that a PCS visit would be made in late June to plan for PCS assistance to ATBEF.

During the team's debriefing with ATBEF, the possibility of a geographically-targeted approach to program and training development and implementation was discussed. Although ATBEF had no problem with the idea, they were concerned that the approach might slow down implementation of ATBEF's program. The INTRAH team reassured ATBEF that its program activities should not in any way be affected, explaining that INTRAH wanted ATBEF participation in the geographic approach, not its entire effort. Thereafter, ATBEF appeared to be supportive, agreeing that the idea was good and that CBD should be added to the program services.

ATBEF also urged that clinical training and clinical updates be conducted, but not be restricted to persons from the geographic area selected for Phase I. The INTRAH team responded that in-country training funds were available under the grant agreement and could be expended in that manner if USAID and the MOH so decided. However, the INTRAH team felt that training additional personnel was not a priority; rather, those who have been trained previously should be updated, equipped and supplied to deliver services. The team felt that a doubling of the current

client load could be handled within the existing service network by the previously trained service personnel. The team also said that an IEC strategy should be developed and activated to recruit clients.

IPPF, West Africa office

Objectives for meeting with IPPF were to discuss current activities in Togo and other Francophone countries and to obtain the IPPF's view on INTRAH's intention to use ASBEF in Dakar for regional training of 5 Tchadians.

While the staff generally felt that Dakar would be a good site for regional training because of the infrastructure and adequate client load, they felt INTRAH should be aware of some weaknesses within ASBEF. Although ASBEF is a pioneering institution for FP in Senegal, the IEC component needs strengthening. Also, last year IPPF sent a consultant to Dakar to work with the administrative staff on financial and general management, which are very weak.

Discussion was held on the existence of clinical standards. IPPF provides guidelines, but the associations are generally autonomous and tend to adhere to standards that exist at the national level. IPPF's experience in training in Francophone Africa has revealed that much needs to be done, especially in the area of practical clinical training. IPPF's senior Program Officer, Mr. Alpha Diallo, and the rest of the staff pledged their support to INTRAH's efforts to develop regional training capabilities.

The INTRAH team revisited IPPF before leaving Lomé and during that visit met with the Program Officer for Senegal, Mali, and the Gambia, Ms. Anita Santos, and Program

Officer, Mr. Joseph Karoma (the husband of Mrs. Caroline Karoma). Mr. Karoma supported INTRAH's proposed strategy to assist PNBEF and ATBEF to develop and implement a geographically-phased approach to training and service delivery.

UNICEF

The INTRAH team had both formal and informal meetings with the UNICEF representative, Mr. Peter Delahaye. The major objective of the meeting with UNICEF was to discuss UNICEF initiatives in FP and MCH.

Activities undertaken by UNICEF at the time of the visit included a series of in-service workshops in child survival for sage-femmes. Successful implementation of UNICEF projects has been hindered by some structural constraints, such as the heavy centralization of decision making at the MOH. Other inhibiting factors included the fact that the mèdecin chefs are generally not trained in either management or public health. There is also a lack of experience in outreach programs. For example, the mèdecin chefs do not want the sage-femmes to go outside of their clinic posts into the community, precluding any possibility of outreach activity by the sage femmes. A suggestion was made by the resident UNICEF representative that some of the mèdecin chefs be taken outside of the country to see other experiences in family health programs.

UNICEF has collaborated with the URD in the APEL (Arrival of the Next Child in Lomé) survey which looked at child spacing and FP practices in Lomé. UNICEF has also been playing a key role in trying to coordinate donor activities. Frequent

meetings are hosted to give donors a chance to sit down and share ideas and plans. These meetings help alleviate the problems created by the donor-by-donor negotiation approach favored by the government, which has resulted in much duplication of effort.

UNICEF is also providing equipment for MCH centers, and audio-visual materials and vehicles for health education and immunization activities. It is the UNICEF representative's view that a national plan with an overall perspective must be developed in order that child survival program components be effective.

According to Mr. Delahaye, child spacing is regarded as a component of child survival activities. With proper coordination, FP could be integrated into already accepted activities, such as nutrition, ORT, and so on. However, he did indicate that the national ORT program is very weak and needs much work to improve and strengthen it.

#### UNFPA

UNFPA has been at the forefront in the promotion of population activities in Togo, especially in the public sector. It provided the funding for the creation of the PNBEF in 1977. In 1985 funding stopped and a request was presented by the Togolese government for additional funding, estimated to be around \$760,000. A pre-project for \$267,500 is currently being conducted by the Université Libre de Bruxelles, which has had a resident advisor evaluating the PNBEF. A meeting is scheduled in July 1987 to review the findings and prepare a new project document.

The INTRAH team met with Mr. Yaouvi Fanidji, assistant for Program and Finance. The new UNFPA representative had not yet been appointed. Mr. Fanidji reviewed UNFPA projects, and expressed some reluctance to discuss the future of UNFPA

support to the PNBEF, citing the impending disclosure of the UNFPA advisor's report as the proper channel for obtaining information.

Appendix G. shows a list of UNFPA projects in the country. UNFPA has recently provided funding for out-of-country training for health professionals. One physician was sent to Mauritius for a course on fertility regulation, two to Belgium for clinical family planning training and five for health statistics, and one more person will be sent to Mauritius. Other activities included participation in the recent RAPID presentation with the Futures Group, introduction of family life education in the schools, assistance in the National Census, and sponsoring of a survey on child and juvenile mortality. UNFPA also sponsors the Demographic Research Unit (URD) in a variety of activities. Recently, UNFPA sponsored seminars and workshops for organized women's groups for sensitization on FP. There is a request from the National Union of Togolese Women (UNFT) for three-day seminars on child spacing.

Although Mr. Fanidji insisted that UNFPA is not assisting the government to formulate a population policy, many activities currently being undertaken by UNFPA easily lend themselves to policy formulation. For example, UNFPA is sponsoring a seminar for Ministry of Planning professionals, which is designed to teach them basic demographic terminology. It is hoped that such a course will help them further grasp the concepts to be discussed during the next RAPID follow-on presentation in September 1987.

### In-Service Training

Almost all in-service training in family health had been conducted centrally at the FHTC. Core curricula had been developed and a training team of two sage-femmes and one nurse was assembled and trained. From October 1983 to November 1986, a total of 206 Health and Social Affairs personnel were trained in family health under FPJA auspices. Training for physicians lasted six weeks. Nurses' training lasted seven weeks. Training for sage-femmes and medical assistants lasted eight weeks, and for social workers, an initial course of five weeks was reduced to one of four weeks.

A review of the curricula used for these courses revealed very little FP or other MCH content. Courses relied heavily on out of class reading followed by in-class discussion with faculty from Health and Social Affairs professional schools invited frequently as guest lecturers.

Apart from the FHTC and since the major MOH/SA professional schools have been closed for the last few years, there has not been any real locus for in-service training. UNICEF and other donors sponsor occasional workshops. For example, during the INTRAH team's visit, UNICEF was organizing a child survival in-service training for sage-femmes. However, most government pre-service institutions do not offer any in-service training and say they cannot afford to do so.

According to Dr. Assimadi, activities at the closed Midwifery School have shifted toward retraining health personnel in child survival and other topics, including counseling. No statistics or curricula exist to support or confirm these activities. Regarding the seven faculty of the School, four are teaching at the University, and it is not known what the other three are currently doing.

According to Mr. Ahoulou, National Chief of Nursing Services, three one-week in-service courses for nurses were planned for 1987, two of which have been implemented. The courses had two major components, management and health education. Mr. Ahoulou said that the topics for the course were developed on the basis of trainees' suggestions, problems observed, questioning of field workers and reports from médecin chefs. Other input included indirect indicators, such as low vaccination coverage and ORT practices. No in-service training by the Ministry is reported for categories of health professionals such as sage-femmes auxiliaries or infirmiers auxiliaries.

Of particular interest is the fact that despite all the clinical training that has taken place in Togo, there has never been any in-service course for clinical preceptors. Coordinators and trainers who supervise clinical training apparently perceived the need for in-service clinical preceptor training, but were never provided with it.

The ATBEF clinic in Lomé, one of the major in-service practicum sites, reported that too many trainees were sent to them for each session. Therefore, few trainees had the opportunity to place the required number of IUDs or to practice other basic skills. No accurate data exist to verify how many hours were actually spent in the clinical practicum, but a review of the curricula by the team indicated insufficient time was allotted to insure adequate practice. During practicum sessions, trainees began at 7:30 and stopped at 11:00. The small number of accepters was also a major hindrance to adequate clinical FP training. In addition, there did not appear to be any system for trainee follow-up and there is a serious shortage of training materials, books, handouts, and especially, visual aids.

IV. ASSESSMENT OF FAMILY PLANNING SERVICES

A total of eight clinical facilities were visited, two in Lomé and six in rural areas, by the team of Mirabito, Karoma and Hounzah:

Maritime Region

Zongo MCH Clinic (MOH)

Association Togolaise pour le Bien - Etre Familial (ATBEF)

Kara Region

Dara Regional Hospital

Kara Prefecture

Central Region

Tchamba Prefecture

Sokodè MCH Clinic

Sokodè Regional Hospital

Sotouboua Health Center

The purposes of the site visits were to identify the training needs of staff responsible for providing child-spacing services, including information, education, motivation and clinical services; and, to assess the readiness of the clinics to serve clients.

A. Providers

Family planning services in the public sector are integrated into other health services on a limited basis. Chief medical officers, nurses and medical assistants are responsible for all curative and preventive services including family planning with sage femmes providing maternity care and family planning. For this reason, family planning services are available on a part-time basis in some clinics and are not viewed as a priority among service providers. Information and education are provided by health and social workers. Reportedly, social workers conduct home visits to clients who live within walking distance of the

clinic with women as the primary beneficiaries of the visits since the husbands are working. Information and education services have yet to be made available in markets or to community groups.

Supervision of family planning service providers is made on an ad hoc basis. Chief medical officers are responsible for on-site supervision, but methods of supervision have not been established. The family planning coordinator who is based in Lomé visits the facilities on a monthly basis mainly to collect reports and requests for supplies.

Nearly 100% of the clinic staffs interviewed had participated in the family health training program. The persons interviewed had reference and/or resource materials in their offices; specifically, the IPPF Handbook, and Population Reports, but client education materials were in short supply.

B. Services

All providers interviewed stressed that family planning clients are provided with information regarding all methods of contraception with final choice made by the client, barring medical contraindications. All artificial methods were reportedly available. In reality, however, oral contraceptives were not supplied in many of the clinics.

According to government policy, women who use oral contraceptives are required to have specific laboratory tests prior to prescription of pills. The lack of laboratory facilities, particularly in rural areas, and economic factors (clients must pay for the tests) preclude acceptance of oral contraceptives. In addition, all providers interviewed stated that women will "forget to take the pill," and therefore it was not considered a viable

option. Spermicides, the IUD, and condoms are the most popular methods.

Acceptors do not routinely receive a physical exam although IUD acceptors receive a pelvic exam. Follow-up of IUD acceptors is scheduled according to established standards, however, clients are not pursued if they fail to keep appointments.

Recording and reporting systems varied in the facilities visited. Although client records are available in most centers, the kinds and quality of data varied. According to available records, numbers of clients who received FP services in the previous month ranged from 50 in a rural area to 268 in ATBEF in Lomé. Statistics on acceptors and methods were available in only three facilities, despite the fact that resupply of commodities is based on monthly statistics, although often on an irregular basis (by ATBEF). It is important that a standard data collection system be established for all the facilities, which should reflect actual utilization of services, an accurate inventory of supplies, the tracking of commodities, and that can also encourage client follow-up.

The physical facilities are in need of re-organization, particularly with regard to creating adequate storage areas for commodities. Privacy for clients was available in most of the facilities. Refurbishing and reorganization of facilities will require modest to extensive interventions. The World Bank is planning to conduct an architectural study to determine the extent of repair and refurbishing required for all health facilities.

Supplies and Equipment

If the demand for family planning services increases, an increase in equipment will be essential. At present, there is a shortage of gloves and adequate sterilizing equipment resulting in sterilization techniques that ranged from boiling to flaming with alcohol. The latter method is frequently used when instruments are required for successive IUD insertions.

IV. FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

Findings

1. Trained service personnel are in place. There are enough of them to meet current demand and a doubling of current service load. However, they do need a contraceptive technology update and strengthening of clinical and record keeping skills.
2. The demand for service is perceived as low, which is attributed to a variety of factors: insufficient number of service points; lack of planning; absence of supervision for service providers; attitudes of service personnel, and the low quality of services and the service environment; inadequate supplies and equipment in most facilities; lack of public awareness and an outreach effort; males' objections; females' objections; existing laws and regulations; lack of high-level support; and, use of traditional child-spacing methods.
3. There are no hard data on the actual extent of unmet need for child-spacing services, or on:
  - \* obstacles to service acceptance;
  - \* obstacles to acceptance of the idea of limiting family size;
  - \* current child-spacing practices - - and their effectiveness;
  - \* perceptions about modern methods; and
  - \* practice of modern methods.
4. The only family planning-related research that is going on is conducted by the URD, but the research team lacks a health specialist and a medical anthropologist, and does not involve field-based health personnel on their research project teams. Thus, operational problems have little chance to be subjects of investigation, and application of findings from current research studies is not likely.
5. The result of (3) and (4) above is that a national program -- if there was one -- lacks essential baseline data on which to build a strategy and formulate objectives, two basic elements of a program.
6. There is no national perspective, direction, program, or commonly-held idea about what the family planning message should say to the population.

7. Working collaboration among Health, Social Affairs and ATBEF at the national level is weak, although we were told that at prefecture-level it is satisfactory.
8. The Family Health Training Center, as it is referred to in the FHI-II Project Paper, is a non-entity. The three family health trainers work in WHO's regional training programs, the three coordinators are employed elsewhere, and the library housed in the building donated by USAID has only two shelves of family planning materials--almost all were given by INTRAH five years ago.
9. The family health training curricula used in the FPIA-funded training courses lack a family planning emphasis and are deficient in MCH content. They rely on heavy input from physician and other lecturers.
10. The clinical practicum standards lack any attention to sterile technique, and the practicum duration is short (two weeks) compared to the theoretical input (five weeks). Substandard methods of equipment sterilization require immediate attention to avoid possible transmission of potentially serious infections to clients and providers.
11. With one exception, the clinics visited all need upgrading of some kind. A water supply is essential for sterile technique and that is an urgent need. Furniture, supplies, equipment, educational/informational materials, reference materials and general maintenance are also needed.
12. ATBEF is perceived as a credible family planning institution.
13. There are prospects for World Bank and UNFPA support. We don't know much about the prospects, but not from lack of trying to find out.

### Conclusions

1. The Project Paper directs INTRAH to work with the PNBEF which does not exist as a program or project, and the FHTC which is a non-entity, following generally the design of the FPIA-assisted training project. We question whether rejuvenation of all those elements will produce a strong public sector family planning program.
2. GOT support of family planning is not readily apparent, hampering the construction of a national program that is coherent in purpose and implementation.

3. Lack of basic data upon which to base a program strategy, formulate objectives and allocate resources will continue to impede clear thinking about what should be done and how to do it.

### Recommendations

#### A. General

1. Training and technical assistance at the regional or prefecture level is recommended to strengthen existing teams of health care providers, and to develop and/or strengthen the delivery system for providing quality clinic and non-clinic based family planning services.
2. A survey should be conducted to identify knowledge, attitudes and beliefs of men and women in the community at large and in the medical community, regarding child-spacing and the use of contraceptive methods.
3. An inventory of the purported 27 service points should be made after there is agreement on basic requirements or standards that actually constitute a service point.
4. A system for procurement and distribution of supplies and equipment needs to be developed with appropriate personnel.
5. Family planning service providers require a thorough update in contraceptive technology, sexually transmitted diseases, equipment sterilization techniques, and communication skills. An update should include theory and a practicum allowing adequate time for trainees to gain competency in both clinical and non-clinical aspects of services, such as information and education to individuals and groups.
6. Technical assistance and training should be provided to develop and implement a uniform data collection and reporting system for use in improving, monitoring, and evaluating quality and quantity of services and for reordering supplies and commodities.
7. A system for supervision, evaluation, and management of personnel and services should be established in each prefecture in order to assure quality of family planning and other primary health care services. Standards of care should be included. Following the development and implementation of complete family planning services in one pilot rural area, selected personnel from the area should be provided with the opportunity to develop skills enabling them to train personnel in surrounding prefectures.

9. The French edition of Family Planning Methods and Practice: Africa should be sent in quantity to USAID/Lomé for wide distribution starting with those who were trained under the FPIA-assisted project.
10. Ms. Caroline Karoma should be put on the INTRAH TIPS mailing list for French and English TIPS, and should be sent copies of clinic inventory check lists that are in INTRAH's files.

B. INTRAH

The team recommends that INTRAH pursue a geographically-phased approach emphasizing program and training development.

1. Start with a national roundtable of Health, Social Affairs and ATBEF representatives to discuss the grant agreement and the implications for each organization. Decide on a geographic area where a collaborative program could successfully be undertaken.
2. Once the area is selected, have a roundtable of local representatives from the same entities, together with any donors working in the area, to determine the information required to develop a program, and to formulate a plan (how/who/when) for information gathering.
3. Analyze the information collected, and with the group in (2):
  - a. conduct a training needs assessment.
  - b. formulate ideas for IEC approaches and materials, with PCS.
  - c. develop a program plan (outreach, services and service standards, supervision, record-keeping/reporting, follow-up monitoring, evaluation, supplies/equipment) and identify who will be responsible for what.
  - d. develop a training plan
4. Implement.
5. Review and evaluate.
6. Use lessons learned in another geographic area.

This approach will permit mobilization of local resources in combination with external assistance, and will activate

local counterparts of national entities to play major roles in a program which is meant to benefit the people they serve.

INTRAH is willing to help with all phases of this approach, and believes the team of three trainers (now at the WHO training center) should be involved also.

C. Next Steps

1. INTRAH/WCA will make a project development visit in September to work on the roundtables, and will discuss Columbia's interest in helping with the information-gathering phase of the strategy.
2. PCS should be informed of the need for their help during the planning phases.
3. The clinic inventory should be started as soon as Project funds are released.
4. Ms. Karoma will be put on the INTRAH mailing list for materials in French and English.
5. Mr. Gaye will debrief Dr. Sarah Clark, REDSO/WCA, and obtain her views on INTRAH's proposed strategy.

APPENDIX A

PERSONS CONTACTED/MET

The INTRAH team met with Mr. Yaouvi Fanidji, assistant for Program and Finance. The new UNFPA representative had not yet been appointed. Mr. Fanidji reviewed UNFPA projects, and expressed some reluctance to discuss the future of UNFPA

PERSONS CONTACTED/MET

USAID/Lomé

Ms. Barbara HOWARD, Acting Director  
Mr. Ernie POPP, Development Officer  
Ms. Caroline KAROMA, FP Project Coordinator  
Mr. Louis O'BRIEN, Technical Advisor, Water and Sanitation Project

PEACE CORPS

Mr. Joseph NAIMOLI, Volunteer

MINISTRY OF HEALTH

Dr. Tognide HOUENASSOU-Houangbe, Director General for Public Health  
Dr. Vignon R. DEVO, Director of the MCH Division  
Ms. N. HOUNZAH, Clinical Coordinator, MCH  
Mr. AHOULOU, Head of Nursing Services  
Dr. Tchasselu KARSA, Director of the Epidemiology Division  
Ms. Adjiba AJBOKOU, Midwife, Regional Hospital, Atakpame  
Mr. Dekor AGBETI, Administrator of the Kpalime Hospital  
Dr. K. KPOTSRA, Chief of Medicine, Kpalime Prefecture  
Dr. K. ASSIMADI, Chief of Pediatrics, CHU and Principal School for Midwives  
Dr. A.K.S. HOUDONOU, Professor of OB/GYN at the CHU, Lomé  
Mr. N. GNON-MANLEY, administrative sector, Office of the Director General

MINISTRY OF PLANNING

Mr. Kouami HOUNGEZ, Health Planner

DIRECTORATE OF SOCIAL AFFAIRS

Ms. Adjoa WOMAS, Chief of Training

Ms. DEGBAU, Director of Social Center, Lomé

WHO TRAINING CENTER

Dr. Ayite D'ALMEIDA, Director of Studies

Mr. Erroll WILLIAMS, Health Education Specialist and Acting  
WHO Representative

Mr. MEMEN, Trainer

Ms. AYAOUSSOU, Trainer

Ms. TETOU, Trainer

UNICEF

Mr. Peter DELAHAYE, Resident Representative

ATBEF

Mr. Kwasi MENSAH, Executive Director

Ms. Enyonam MENSAH, Clinical Director

Mr. Lenyo Kpédji MATHE, Program and Training Director

IPPF, WEST AFRICA

Mr. Alpha DIALLO, Senior Program Officer

Mr. Joseph M. KAROMA, In-Charge of Programs

Dr. MWOMBA, Program Officer

Ms. Anita SANTOS, Program Officer (Mali, the Gambia,  
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UNFPA

Mr. Yaouvi FANIDJI, Assistant for Program and Finance

**TOGOPHARMA**

Mr. Komlan FONGBEMI, Director of Production

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Ms. Kaga TCHIKPEDE, Sage Femme

**KARA PREFECTURE**

Dr. JAGBASSOU, Chief Medical Officer

**TCHAMBA**

Dr. Margah KOOJO, Chief Medical Officer

**SOKODÉ MCH CENTER**

Dr. AFLGAK, Chief Medical Officer

Mr. Adanto SEWONA, Medical Assistant

Ms. BANABESSE, Sage Femme

Ms. Avena RABI, Sage Femme

**SOKODÉ REGIONAL HOSPITAL**

Ms. DIJIBRO, Sage Femme

SOTOUBOUA HEALTH CENTER

Dr. TAIROU, Chief Medical Officer

ZONGO FP CLINIC

Ms. ABOUSSA, Sage Femme

Ms. KONOU, Social Worker

APPENDIX B

SUMMARY AND MID-VISIT REPORTS  
OF INTRAH TEAM'S NEEDS ASSESSMENT VISIT

# Program for International Training in Health

The University of North Carolina at Chapel Hill  
School of Medicine

## APPENDIX B<sub>1</sub>

### MEMORANDUM

208 North Columbia Street (344A)  
Chapel Hill, North Carolina 27514

File: INTRAH, Chapel Hill, N.C.  
Telephone: (919) 968-5638  
TL: 3772242  
ANSWERBACK: UNCCHINTRAH

**TO:** Ernie Popp  
**FROM:** Pape Gaye and Lynn Knauff  
**DATE:** June 14, 1987  
**SUBJECT:** Mid-visit report

1. We have learned that there is no Family Health Training Center. The WHO Regional Training Center encompassed the USAID-financed building and was the site for family health courses conducted during 1985 and 1986.
2. The three trainers (Madame Ayassou, Mr. Memen and Madame Tetou) who facilitated the family health training are currently employed at the WHO Training Center and assist with regional training. They reported to us that they and their family health trainees knew that the required equipment, supplies and other requirements for service would be lacking after return to post, but that the training project was attempting to meet numerical training targets, not service requirements.
3. The three trainers cited a need for training of clinical preceptors if family health clinical training is to recommence.
4. The three Coordinators (who were paid by FPIA) are employed as follows: Madame Hounzah works with Dr. Devo, Mr. Gnon-Manley works in the DG's office, and Madame Kankarti works in the Directorate of Women's Condition.
5. The family health curricula we reviewed revealed very little family health content and the schedules appear to show that the training day was only four hours long, which may account for the lengthy training durations.
6. The UNFPA Program Officer we met indicated some doubt about future support of the PNBEF program.
7. Seven clinics have been visited outside of Lomé. Zongo and Tokoin were visited in Lomé. All except Tokoin require rehabilitation and/or basic equipment and supplies, and an outreach program for recruiting and following-up clients.
8. Trained personnel staffed the clinics, but they are not using their training.

**intrah**

9. The clinic-based personnel reported the following as needs:
  - a. a contraceptive update
  - b. supplies and equipment
  - c. IEC materials and reference materials
  - d. raising of public awareness about family planning.
  
10. We observed the following needs:
  - a. all those in (9) above.
  - b. agreement on the messages for recruitment after studies are conducted that establish current child-spacing patterns and perceived obstacles to family planning services.
  - c. leadership of the program that guides its development, management and supervision.
  - d. training of community-level workers in how to include family planning in their other information and educational work.
  - e. a review of the current regulations and policies regarding who is eligible for services and under what conditions.
  - f. every purported service point should be visited to establish what is really going on and what is needed-- both for MCH and family planning.
  - g. the place of AIDS education and information in the MCH/FP program should be identified.
  - h. training in and supervision of sterile technique are urgently required on-site, not at a training center.
  - i. Caroline Karoma's role needs to be clarified: who is her Togolese counterpart and what program is she to coordinate?

We have observed that there is no national program and, so far no keen interest in establishment of one except by ATBEF. We are wondering whether training on a country-wide basis will serve a useful purpose in the absence of a service plan and program.

We will be seeing more of those who have been involved in the PNBEF, this week. We hope you will be able to meet with us on Friday, June 19 at 10 AM for a debriefing.

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# Program for International Training in Health

The University of North Carolina at Chapel Hill  
School of Medicine

## APPENDIX B<sub>2</sub>

208 North Columbia Street (344A)  
Chapel Hill, North Carolina 27514

## MEMORANDUM

Cable: INTRAH, Chapel Hill, N.C.  
Telephone: (919) 966-5636  
TLX 3772242  
ANSWERBACK: UNCCHINTRAH

**TO:** Ernie Popp

**FROM:** Lynn Knauff and Pape Gaye

**DATE:** June 19, 1987

**SUBJECT:** Summary Report of INTRAH Team's  
Needs Assessment Visit

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The purpose of this visit, made by three INTRAH staff, was to conduct a training needs assessment. The assessment instrument used by INTRAH includes the policy and program contexts which training is intended to support, and views "needs" as those perceived, expressed and observed from a variety of perspectives.

Here, we used the Project paper as a guide, examining the assumptions made in it, the status of entities with which INTRAH is expected to work -- or affect -- during project implementation, and identifying elements/resources that might be brought to bear on problems uncovered during the assessment.

The INTRAH team (Knauff, Gaye and Mirabito) arrived on June 3. They visited four of five regions, and have interviewed/met with almost 60 persons from governmental, non-governmental and external assistance organizations. The following constitute our summary findings, conclusions and recommendations. A full report will be sent to you in the next several months.

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The logo for INTRAH, featuring a globe icon to the left of the word "intrah" in a stylized, lowercase font.

## OBSERVATIONS

1. Trained service personnel are in place. There are enough of them to meet current demand and a doubling of current service load.
2. The demand for service is perceived as low, which is attributed to a variety of factors: insufficient number of service points, attitudes of service personnel and the quality of service and the service environment, lack of public awareness and an outreach effort, males' objections, females' objections, existing laws and regulations, lack of high-level support, use of traditional child-spacing methods.
3. There are no hard data on the actual extent of unmet need for child-spacing services, or on:
  - - obstacles to service acceptance
  - - obstacles to the acceptance of the idea of limiting family size
  - - current child-spacing practices - - and their effectiveness
  - - perceptions about modern methods
  - - practice of modern methods
4. The only family planning-related research that is going on is conducted by the URD, and the research team lacks a health specialist and a medical anthropologist, and the URD does not involve field-based health personnel on their research project teams. Thus, operational problems are not subjects of investigation.
5. The result of (3) and (4) above is that a national program - - if there was one - - lacks essential baseline data on which to build a strategy and formulate objectives - - two basic elements of a program.
6. There is no national perspective, direction or program, or commonly-held idea about what the family planning message should say to the population.

7. Working collaboration among Health, Social Affairs and ATBEF at the national level is weak, although we were told that at prefecture-level it is satisfactory.
8. The Family Health Training Center as it is referred to in the Project Paper is a non-entity. The three family health trainers work in WHO's regional training programs, the three coordinators are employed elsewhere, and the library housed in the building donated by USAID has only two shelves of family planning materials - - almost all were given by INTRAH five years ago.
9. The family health training curricula used in the FPIA-funded training courses were reviewed. They lack a family planning emphasis and are deficient in MCH content. They rely on heavy input from physician lecturers.
10. The clinical practicum standards lack any attention to sterile technique, and the practicum duration is short (two weeks) compared to the theoretical input (5 weeks).
11. With one exception, the clinics visited all need upgrading of some kind. A water supply is essential for sterile technique and that is an urgent need. Furniture, supplies, equipment, educational/informational materials, reference materials and general maintenance are also needed.  
An inventory of the purported 27 service points should be made after there is agreement on basic requirements of/standards for service points.
12. ATBEF is perceived as a credible family planning institution.
13. There prospects for World Bank and UNFP support. We don't know much about the prospects, but not from lack of trying to find out.

## CONCLUSIONS

1. The Project Paper directs INTRAH to work with the PNBEF which does not exist as a program or project, and the FHTC which is a non-entity, following generally the design of the FPIA-assisted training project. We question whether re-juvenation of all those elements will produce a strong public sector family planning program.
2. GOT support of family planning is not readily apparent, hampering the construction of a national program that is coherent in purpose and implementation.
3. Lack of basic data upon which to base a strategy, formulate objectives and allocate resources will continue to impede clear thinking about what should be done, and how to do it.

## RECOMMENDATIONS

1. We suggest a geographically-phased approach to program development and implementation.
2. Start with a national round table of Health, Social Affairs and ATBEF to discuss the grant agreement and the implications for each organization. Decide on a geographic area where a collaborative program could successfully be undertaken.
3. Once the area is selected, have a roundtable of local representatives from the same entities, together with any donors working in the area to determine the information required to develop a program, and how/who/when of information gathering.
4. Analyze the information collected, and with the group in (3):
  - a. conduct a training needs assessment.
  - b. formulate ideas for IEC approaches and materials, with PCS.

- c. develop a program (outreach, services, supervision, record-keeping/reporting, monitoring, evaluation, supplies/equipment) and identify who will be responsible for what.
  - d. develop a training plan.
5. Implement.
  6. Review and evaluate.
  7. Use lessons learned in another geographic area.

This approach will permit mobilization of local resources in combination with external assistance, and will activate local counterparts of national entities to play major roles in a program which is meant to benefit the people they serve.

INTRAH is willing to help with all phases of this approach, and believes the team of 3 trainers (now in the WHO training program) should be involved, too.

#### NEXT STEPS

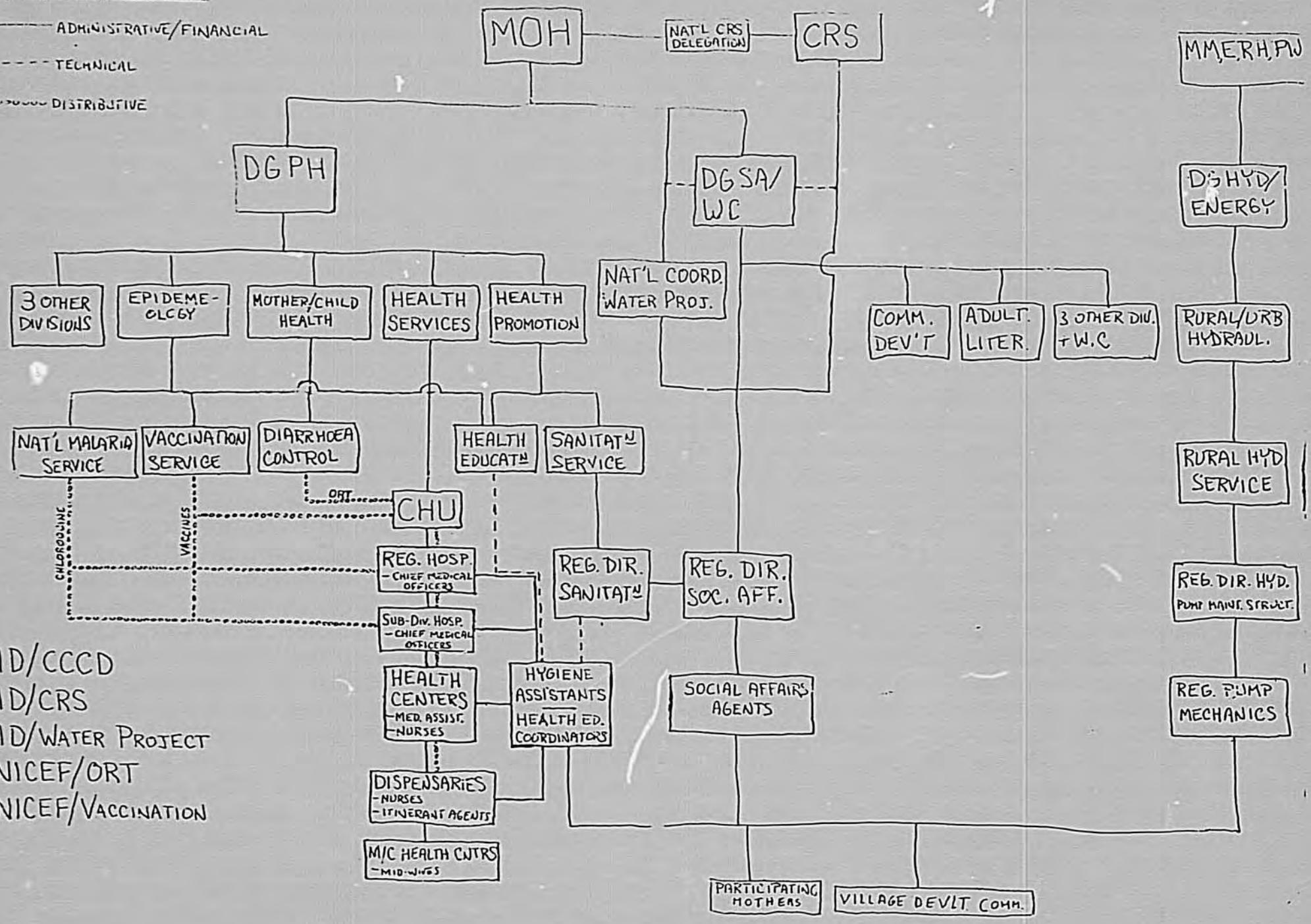
1. INTRAH will make a project development visit in September to work on the roundtables, and will discuss Columbia's interest in helping with the information-gathering.
2. PCS should be informed of the need for their help.
3. The clinic inventory process should be started as soon as Project funds are released.

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APPENDIX C  
ORGANOGRAM OF THE MINISTRY OF HEALTH

ORGANIZATIONAL RELATIONSHIPS

— ADMINISTRATIVE/FINANCIAL  
 - - - TECHNICAL  
 ~~~~~ DISTRIBUTIVE



AID/CCCD  
 AID/CRS  
 AID/WATER PROJECT  
 UNICEF/ORT  
 UNICEF/VACCINATION

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APPENDIX G

UNFPA LISTE DES PROJETS

UNFPA  
LISTE DES PROJETS

| N° du Projet                   | Titre                                                                                             | Responsable                        |
|--------------------------------|---------------------------------------------------------------------------------------------------|------------------------------------|
| 1. TOG/76/PO3                  | Programme National pour le Bien-être Familial                                                     | Dr Dévo Roméde                     |
| TOG/86/PO3                     | Programme National de Santé Familiale                                                             | Dr Dévo Roméde                     |
| 2. TOG/78/PO1                  | Enquête sur la Mortalité infantile et Juvénile à Lomé                                             | Mr Bouraïma Nouridine              |
| TOG/79/PO1                     | Recensement de la Population et Analyses Post-Sensitaires                                         | Mr Bouraïma Nouridine              |
| 3. TOG/85/PO                   | Renforcement des Capacités de la Division de Démographie et de Statistique Sociales               | M Bouraïma Nouridine               |
| 4. TOG/80/PO1                  | Appui à la Formation et à la Recherche démographique à l'Université du Bénin                      | Mme Locoh<br>Mr Koffi Gbodossou    |
| TOG/85/PO4                     | Extension des Activités de Formation et de Recherche Démographique à l'Université du Bénin        | Mr Koffi Gbodossou                 |
| 5. TOG/84/PO2                  | Introduction de l'Education en Matière de Population à la Vie Familiale dans les Ecoles           | Mr Agbekponou Akouété              |
| 6. TOG/86/PO1                  | Séminaires/Ateliers de Formation pour les encadreurs ruraux                                       | Mme Aithnard                       |
| 7. TOG/86/PO2                  | Séminaire de Formation de 200 responsables de l'Union Nationale des Femmes du Togo (UNFT)         | Mme Ayélé Nubukpo                  |
| 8. RAF/85/P17<br><i>Région</i> | National Application of Recommendations for Implementation of the World Population Plan of Action |                                    |
| TOG/86/P40                     | UNFPA Office (Togo)                                                                               | Responsable<br>Mme Eva-Maria Wiese |