PD-ABA-023
63360

# EVALUATION

# HEALTH SECTOR SUPPORT FOR CHILD SURVIVAL PROJECT
(693-0228)

TOGO

JULY 17 - AUGUST 7, 1989

# EVALUATION OF
# HEALTH SECTOR SUPPORT FOR CHILD SURVIVAL PROJECT 693-0228

## TABLE OF CONTENTS


| | page |
|---|---|
| Acronyms | v |
| 1.0 Executive Summary | 1 |
| 1.1 Purpose of the project evaluated | 1 |
| 1.2 Purpose of the evaluation and methodology used | 1 |
| 1.3 Findings and conclusions | 1 |
| 1.4 Recommendations | 3 |
| 1.5 Lessons learned | 4 |
| 2.0 Introduction | 5 |
| 2.1 Purpose of the evaluation | 5 |
| 2.2 Evaluation team | 5 |
| 2.3 Evaluation methodology | 5 |
| 2.4 Acknowledgments | 5 |
| 3.0 Analysis of Project Concept and Rationale | 7 |
| 3.1 Findings | 7 |
| Planning and Coordination Unit | 7 |
| Health Centers Support | 8 |
| Community Outreach | 8 |
| 3.2 Conclusions | 9 |
| 4.0 Analysis of Structural Questions | 11 |
| 4.1 Findings | |
| Position of the Government of Togo vis-a-vis the PCU | 11 |
| Recognition of the PCU by its peers | 12 |
| Connection with the Rural Water Supply and Sanitation project | 13 |
| Staffing | 14 |
| 4.2 Conclusions | 15 |
| Position of the GOT vis-a-vis the PCU | 15 |
| Recognition of the PCU by its peers | 16 |
| Connection with the Rural Water Supply and Sanitation project | 17 |
| Staffing | 18 |
| Effectiveness | 20 |
| 4.3 Recommendations | 20 |

page

5.0 Project Performance Relative to Planned Outputs and Implementation Schedule 25

5.1 Findings 25
Project Outputs 25
Implementation Schedule 25
Reasons for Low Output Achievement 26

5.2 Conclusions 29
Salary supplements 29
Responsiveness to action requests 31

5.3 Recommendations 31

6.0 Other Program and Technical Issues 37

6.1 Appropriateness of project objectives and of combination of components 37
6.2 Appropriateness of excluding child survival service provision 38
6.3 Questions of project focus 38
6.4 Collection of baseline data and establishment of benchmarks 41
6.5 Other technical issues 42
6.6 Participation of women 43
6.7 Effectiveness of PCU in donor coordination 45
6.8 Construction component 46

7.0 Administrative Issues 51

7.1 Overall project management by the grantee, AID and the contractors 51
7.2 Contract scope of work and procurement 55

8.0 Compliance with Conditions Precedent (CPs) 59

8.1 Findings 59
8.2 Conclusions 62

9.0 Lessons Learned 65

9.1 Need for high-level support 65
9.2 Late arrival of technicians 65
9.3 Merging of project staffs 65

## Resume of Recommendations

Chapter 4: 23 recommendations on project structure stated as basic principles

Chapter 5: 16 recommendations, of which 15 are benchmarks related to above principles

Chapter 6: 7 recommendations on program and technical issues

Chapter 7: 6 recommendations on administrative issues

**Annexes**


| | | page |
|---|---|---|
| 1. | Project Outputs | 67 |
| 2. | Excerpts from Project Implementation Report 3/31/89 | 73 |
| 3. | Implementation Schedule per Project Agreement | 79 |
| 4. | Review of Togo's Child Survival Programs and Policies | 85 |
| 5. | Relation of PCU to Ministry of Plan | 91 |
| 6. | List of Persons Contacted | 93 |
| 7. | Evaluation Scope of Work | 97 |

## ACRONYMS

| | |
|---|---|
| ADS | Accord de subvention |
| AID | Agency for International Development |
| AID/AFR | AID's Bureau for Africa |
| CAP | Connaissances-attitudes-pratiques |
| CCCD | Combating Childhood Communicable Diseases project |
| CDD | Control of diarrheal diseases |
| COP | Chief of (contract) party |
| CP | Condition precedent - Condition préalable |
| CPC | Cellule de Planification et de Coordination (ministry office) |
| CS | Child survival |
| CVD | Comité villageois de développement |
| DAC | Development Assistance Corporation (project contractor) |
| DANIDA | Danish International Development Agency |
| DME | Division de la Mère et de l'Enfant |
| EPI | Expanded Program of Immunization |
| FAC | Fonds d'Aide et de Coopération (French aid agency) |
| FED | Fonds Européen de Développement |
| GDT | Gouvernement du Togo |
| GOT | Government of Togo |
| HIS | Health information system |
| HSSCS | Health Sector Support for Child Survival project |
| IEC | Information, education and communication |
| KAP | Knowledge-attitudes-practices |
| LEP | Lettre d'exécution de projet |
| MCD | Medical Care Development (project sub-contractor) |
| MCH | Maternal and child health |
| MPHSAWC | Ministry of Public Health, Social Affairs and Women's Condition |
| MSPASCF | Ministère de la Santé Publique, des Affaires Sociales, et de la Condition Féminine |
| NGO | Non-governmental organization |
| ONG | Organisation non-gouvernemental |
| ORT | Oral rehydration therapy |
| PCU | Planning and Coordination Unit (project entity) |
| PHC | Primary health care |
| PIL | Project implementation letter |
| PIO/T | Project implementation order for technicians |
| ProAg | Project grant agreement |
| PSC | Personal services contract |
| PSE | Projet de Survie de l'Enfant |
| REDSO/WCA | Regional Economic Development Services Office/West and Central Africa (AID regional office in Abidjan) |
| RWSSP | Rural Water Supply and Sanitation project |
| SNES | Service National de l'Education Sanitaire - National Health Education Service |
| TA | Technical assistance |
| UNFPA | United Nations Fund for Population Activities |
| UNICEF | United Nation's Children's Fund |
| UPC | Unité de Planification et de Coordination |
| USAID | United States Agency for International Development (refers to AID country mission) |
| VDC | Village development committee |
| USO | Unité de Soutien aux Opérations de Survie de l'Enfant |
| WHO | World Health Organization |

# 1.0 EXECUTIVE SUMMARY

**Mid-term Evaluation of USAID/Government of Togo Project 693-0228**
**Health Sector Support for Child Survival (HSSCS)**
**July-August 1989**

**1.1 Purpose of the project evaluated.** The purpose of the project is to assist the Government of Togo (GOT) to plan, manage and coordinate the delivery of child survival (CS) services in a rational, cost-effective way. Although Togo has made impressive strides in controlling childhood diseases, infant and child morbidity and mortality still are unacceptably high. AID and other donors are supporting GOT programs of vaccination, immunization, control of diarrheal diseases, etc. The HSSCS project seeks to improve the effectiveness of these programs through: a **planning and coordination unit (PCU)** to develop a Togolese capacity to plan, budget and coordinate CS activities both at the central level and between central, regional and local levels; a **health centers support component** to train health education teams in communication and health education techniques, and to provide them with means of transport (motorcycles and operating/maintenance costs), so that they in turn can train rural public health personnel; and a **community outreach component** to train community agents and village development committees (VDCs) in community mobilization techniques and CS topics, and to provide the agents with means of transport. The first two components are national in scope; the third component is limited to two regions where VDCs were developed under a previous USAID rural water supply project.

**1.2 Purpose of the evaluation and methodology used.** This is a mid-term evaluation mandated by the project agreement to (a) assess progress after nearly two years of activity, and (b) determine whether there has been "evidence of sufficient GOT commitment to the project . . . to warrant a recommendation for project continuation." Commitment is defined by a series of conditions precedent (CPs) to continued disbursement of AID funds for the project after the second year.

The team conducted interviews in Lome with Togolese and expatriate project personnel, leading officials of the Ministry of Public Health, Social Affairs and Women's Condition (MPHSAWC), USAID officers, a contractor representative, and other donor officials. The team visited a project field center and met with regional officials and project personnel. The evaluators also consulted basic project documents, progress reports, and technical documents produced under the project.

**1.3 Findings and conclusions.** The team found a strong expressed interest in improved CS planning and coordination within both the GOT and the donor community. The GOT backed up its interest with timely financial contributions to HSSCS. Nevertheless, the project has been blocked from achieving its objectives since almost the beginning. Only if the GOT -- in cooperattion with the contract advisory team and USAID -- makes

a determined effort over the next few months to remove the obstacles identified herein, will the project have a chance to produce results of sustainable developmental value.

The evaluators found the rationale of the project, combining a conceptual component with operational support units, to be sound. The heart of the project is the PCU; the operational components (a) provide incentive to central and field services of the MPHSAWC to participate in the planning and coordination process fostered by the PCU, and (b) facilitate the transfer of CS knowledge, skills and services to the village level.

However, the project concept presupposes a readiness on the part of the GOT to alter a planning process that is vertical by virtue of (a) the division of MPHSAWC into three largely independent directorate generals, and (b) the GOT and donor practice of planning and budgeting for CS in program-by-program fashion. This pattern has proven to be highly resistant to change at the central level: at the regional and prefecture levels where implementation takes place, integration of activities and personnel is more advanced. Single-program and single-policy reviews are essential as far as they go, but the aim of the project is to supplement the vertical process with a system of horizontal, integrated planning that can weigh alternative options and establish priorities of implementation sequence and resource allocation. To date the PCU has co-sponsored a workshop with other donors to consider annual plans for CS programs, and participated in a number of single-issue gatherings. However, it has been too weak to establish integrated planning and budgeting as a norm.

The PCU's weakness stems from the following causes:

- It has no defined position within the ministry's hierarchy, despite agreement with USAID to place it close to the minister. Since the PCU director also serves as head of Maternal and Child Health under the Director General of Public Health, it is unclear whether the PCU is providing its technical services above or below the director general level.

- Other factors add to the ambiguity. The project paper and project agreement often refer to the PCU as the entire HSSCS project. In many people's minds, the project, including the PCU, is a mere extension of the highly visible former water supply project, whose staff and procedures were transferred to the current community outreach component. Finally, a long-gestating World Bank project that may encompass general health planning has raised questions about the PCU's role.

- The MPHSAWC has not established the Adivsory Board and National Commission for Child Survival, despite a CP to this effect, and a request for the board's establishment by a major "Tripartite Meeting" on the project in January 1989.

- The PCU director is overburdened with other duties and has only limited planning and administrative experience; one of the CPs, however, called for an experienced, full-time director.

- The coordinator named to the project from the Ministry of Plan has been virtually absent from the project. The only senior Togolese counterpart working full-time with the project is the coordinator from the Directorate General of Social Affairs; he manages the community outreach component.

- The PCU does not use the coordinators principally as planners, as envisioned in the project design. Rather, they devote most of their time to the operational components.

- The near-absence of the director and one of the coordinators, and the assignment of the coordinators to essentially operational duties, has forced the planning advisor -- who is the contract chief of party -- to try to handle planning activities and project supervision largely by herself.

In sum, the PCU has little credibility. Ministry and donor officials are puzzled over its purpose and status. It lacks guidance from advisory bodies. Its senior Togolese contingent is seriously understaffed. Although it has participated usefully in CS planning and policy seminars, it has not been able to establish a forceful, lasting presence in planning and coordination within GOT and donor councils. Little transfer of knowledge and skills has taken place.

The PCU and the operational units have additional handicaps as well as some assets. The community outreach component has a set of tried and tested procedures and good logistic field supervision. The project headquarters is well-housed, well-equipped, and well-staffed with support personnel. However, morale is low. The director is generally absent, yet does not delegate authority. Both the MPHSAWC and USAID have been slow to act on matters of importance to the project. A question of AID salary supplements for the Togolese counterparts remains unresolved. Administrative procedures are loose in certain respects, and the AID and GOT local cost budgets are not well-coordinated. The three components are not properly aligned because (a) the PCU's planning role vis-a-vis the operational units is only now becoming clear to all concerned, and (b) the health centers support component is lagging because the National Health Education Service (SNES) has been slow to accept project participation, develop a health education strategy, and assess its needs.

**1.4 Recommendations.** The many non-technical constraints besetting the project have kept its professionals from bringing their technical capabilities fully to bear. The evaluators recommend a series of steps to "unblock" the project by November 30, 1989. In December a mini-evaluation should take place to determine (a) whether the blockage has been cleared and the project can usefully continue, and (b), if continuation is deemed appropriate, whether modifications to the project are advisable.

The most urgent recommendations are that the Minister of Public Health, Social Affairs and Women's Condition attach the PCU to his cabinet; name a full-time director for the HSSCS project and the PCU, and appoint him as technical advisor within the cabinet; establish the ministry's Planning and Coordination Cell as the project Advisory Board; create under the Board a National Commission and an Ad Hoc Committee for Child Survival (with the latter to begin meeting in October); add a coordinator from the Directorate General of Women's Condition to ensure complete ministry representation in the PCU (this was not included in the original project design); and respond to other recommendations of the Tripartite Meeting of January.

The team further recommends that the following benchmarks be achieved by November 30: The project director demonstrates strong leadership qualities and administrative ability, and either has substantial health planning experience or is ready to learn on-site with the help of the expatriate advisor. The latter begins holding intensive training seminars for the senior Togolese staff. The PCU is made the principal locus for the work of the director, planning advisor and coordinators, with day-to-day management of the operational components assigned to new assistants from Social Affairs and SNES. All coordinators are available full-time to the project. USAID resolves the question of salary supplements. The project and USAID agree on plans for a major planning/budgeting seminar for health officials. A long-delayed seminar on SNES objectives and needs is held. The project team develops detailed work plans and includes among its tasks a public relations campaign to clarify the role of the PCU as a conceptual body in CS matters, distinct from the operational components of the project. USAID and the ministry agree on candidates for long-term U.S. training.

Longer-term recommendations include calls for systematic data collecti[illegible] and documentation of project contributions, improved administ[illegible]ve and budget procedures, better coordination with other US[illegible] health programs and Peace Corps, and increased communic[illegible] between the project and USAID.

**1.5 Lessons learned.** No project seeking to introduce new institutional patterns can succeed without strong policy support from the host government. Project designers should seek to ensure in advance of project inception that such support will be forthcoming. The designers should also be aware that a project of this nature is difficult to launch on a proper footing if the advisors are not on-site to work with their counterparts from the outset. This means the starting date of a project may have to be delayed to allow for the advisors' arrival.

Whenever a project incorporates staff from a prior project in order to build upon its achievements, those persons should promptly be inculcated in the objectives of the new project so as to block the notion that the old objectives are still paramount.

# 2.0 INTRODUCTION

**2.1 Purpose of the evaluation.** This is a mid-term evaluation mandated by the project agreement to assess progress in achieving project objectives, and to determine whether there has been "evidence of sufficient GOT commitment to the project during the first twenty-one months to warrant a recommendation for project continuation." Commitment is defined by a series of conditions precedent (CPs) to continued disbursement of AID funds beyond the twenty-fourth project month. The CPs are discussed in detail in Chapter 8. The project agreement was signed on September 7, 1987; the evaluation was carried out in July and August 1989.

**2.2 Evaluation team.** The evaluation team consisted of Walter Sherwin, consultant in development program planning and management, who served as team leader; Dr. Charles DeBose, Senior Regional Health and Population Officer from the AID regional office, REDSO/WCA, in Abidjan; Dr. Charles Tilquin, consultant in health planning and Director of Operational Research in Public Health at the Faculty of Medicine, University of Montreal; Dr. Vignon Devo, Technical Advisor to the Minister of Public Health, Social Affairs and Women's Condition, Government of Togo; and Mr. Kodjo Zoland, Director of the Division of Socio-Cultural Development, Ministry of Plan, Government of Togo.

**2.3 Evaluation methodology.** The team assembled in Lome on July 17, 1989, and completed its in-country work on August 7. The team began by carrying out a week of interviews with Togolese and expatriate project personnel, the Minister of Public Health, Social Affairs and Women's Condition, other leading officials of the ministry, representatives of other donors involved in child survival activities, USAID officials, and a home office representative of the contract technical assistance team. The team also spent a day visiting project field operations in and near Atakpame in the Plateaux region. There they witnessed a training session for village development committee (VDC) leaders; interviewed regional officials of Plan, Social Affairs and Public Health; and met with the accountant for HSSCS project regional operations.

The team consulted the project paper, project agreement, project implementation letters, the technical assistance contract with Develpment Assistance Corporation, progress reports, project budgets, work plans, reports on child survival planning activities in which the project team participated, training manuals, and ministry and project organization charts.

**2.4 Acknowledgments.** The evaluators received superb cooperation from the project team, the Government of Togo and USAID. The project director and the chief of party arranged the interviews and the field trip with great efficiency, and provided the team with all necessary transportation. All the persons interviewed were gracious with their time and fully

responsive to the evaluators' questions. Both the project team and USAID generously made office space and facilities available. Requested documents were promptly provided. The expatriate members of the evaluation team wish to give special acknowledgment to their Togolese colleagues for the perceptive insights they provided, and for their exceptional collaboration, including a readiness to participate in after-hours brainstorming sessions.

# 3.0 ANALYSIS OF PROJECT CONCEPT AND RATIONALE

This chapter deals with the conceptual foundation of the project, with particular reference to the combination of its three components. Project performance is treated in subsequent chapters.

## 3.1 FINDINGS

It is possible to reduce Togo's infant mortality rate through a three-pronged strategy. One level is a direct operational approach to reduce the incidence of childhood diseases by improving service delivery, training of health center and village outreach staff, and instituting appropriate interventions such as oral rehydration therapy (ORT), malaria prevention and control, and increasing the immunization level in villages. To be effective at the village service level, however, major attention must also be given to improving the planning and coordination of policies, programs and health resources. The planners of this project believed that this combination of approaches would result in substantial health status improvement, and could eventually result in a reasonably effective primary health care system with emphasis on child survival.

The goal of the project is to improve the health status of Togolese children under five years of age and women. Achievement of this goal can be measured by a decrease in infant mortality, and a decline in the incidence of major childhood communicable diseases. The project purpose is to assist the Government of Togo (GOT) to plan, manage and coordinate the delivery of child survival services in a rational, cost-effective way. To achieve the goal and purpose, the project focuses on the major health and planning/ coordination problems which can make a significant difference to delivery of child survival services, and a concomitant improvement in maternal and child health status.

The intent of this project is to support the Ministry of Public Health, Social Affairs and Women's Condition's (MPHSAWC) present strategy to improve and extend the rural health delivery system through institutional development and support for planning and coordination, support to health centers, and development of a village outreach network.

### Planning and Coordination Unit

The first component is more conceptual in nature, while the other two components are more operational. The conceptual component is designed to operate through a Planning and Coordination Unit (PCU) reporting to the Minister of Public Health, Social Affairs and Women's Condition. Its mission is to build a capacity to plan, budget and coordinate child survival activities at the central level and between central,

regional and local levels of government. The aim is improved planning and coordination both between different offices and levels of government and between different child survival programs. Accomplishment of this objective should facilitate and go hand-in-hand with the achievement of other changes not directly addressed by this project. The institutional support system for logistical services and equipment, drugs and supplies, transportation, and health care and support facilities need to be strengthened and expanded throughout the country by GOT with other donor assistance. The MPHSAWC recognizes the need to decentralize planning and managerial functions to regional and prefecture levels. To help guide the planning process, a network of advisory groups and commissions is necessary at various levels of government. The PCU, for example, is to be guided by an advisory board and a national commission for child survival.

Health Centers Support

This component, more operational than the first, is designed to improve the knowledge and performance of health center personnel in child survival techniques, interpersonal communications and information, education and communication (IEC) skills in an effort to increase the general population's acceptance and utilization of health services as well as its awareness of the correct approaches for caring for their families at home. This component is to be implemented by training and assigning two health educators from the National Health Education Service (SNES), along with Peace Corps Volunteers, to each of the 21 prefectures in the country. The health team in each prefecture is to be responsible for training other trainers who will deliver health education services to MPHSAWC personnel implementing child survival services.

Community Outreach

The third component of the project, also operational, is the Outreach Network. Project-financed activities under this component supplement and complement those under the Health Center support component by working directly with villagers, assisted by various field workers, to create a network which integrates villagers into the health center level service delivery system. These activities are being undertaken only in Plateaux and Savanna regions, where the previous Rural Water Supply and Sanitation Project (RWSSP) carried out community interventions. That project provided potable water (1,048 wells and 230 rainwater cisterns) and sanitation facilities (450 latrines) to about 630,000 rural inhabitants in about 800 villages, each with a Village Development Committee (VDC) organized and used by the project. About 72 social affairs agents and about 48 sanitation agents were trained and have at least five years experience at this time. The HSSCS Project has incorporated this infrastructure into it, in order to capitalize on the VDCs' experienced agents, and on the institutional linkages developed under RWSSP. The experience

and infrastructure transferred from RWSSP must be tested in meeting the broader objective of the HSSCS community outreach effort. Changing attitudes and behavior in matters of child survival may be more difficult than securing villagers' participation in construction of potable water and latrine facilities. The latter are in great demand, whereas the felt need of villagers for child survival services and preventive health measures is less apparent except during epidemics. Hence the outreach network must be retrained and strengthened to assume the more complicated responsibilities of providing child survival education.

### 3.2 CONCLUSIONS

The major component of the HSSCS Project is the Planning and Coordination component which is conceptual in its implementation. Two operational components, Health Centers Support and the Outreach Network, were designed as part of the project in an attempt to link central level planning and coordination exercises to those providing the services: rural government health services facilities and providers; and to those demanding and using the services: individuals, village families and community groups.

By establishing the Planning and Coordination Unit and at the same time making provision for the delivery of limited child survival support services, the project strategy is more tailored to the critical needs of the rural areas of Togo, not just to the urban areas. Strengths and weaknesses of health service delivery and outreach activities can be addressed in the planning and coordination exercises. Institutional development of th PCU through program planning, training, coordination, implementation and evaluation capabilities, is essential for MOPHSAWC. By having functions at all levels - central, regional and prefectoral - the HSSCS project is in a unique position to help overcome problems of horizontal and vertical coordination among the various MPHSAWC services.

Coordination of child survival program activities within MPHSAWC, as well as among other governmental and non-governmental organizations and donors, should significantly increase the effectiveness and efficiency with which GOT resources are used. The results should be less duplication of effort, more effective sharing of limited resources, and more sustainable child survival services.

While the health centers support component is nation-wide in scope, community outreach covers only two of the five regions: Savanna and Plateaux. Should the latter component be expanded?

The community outreach component and its methodology stem directly from the RWSS project which concentrated on the two regions mentioned. The methodology involves working directly with village development committees created under the previous project. These do not exist in most of the rest of the country, and it would not be feasible for the community outreach component to expand to a national level given the limited resources and time available to the project. However, the component can serve as a model for the GOT and other donors to replicate the system in other regions.

By contrast, the health centers support component can function at a national level because of its training-of-trainers approach. Its coordination with community outreach can also serve as a model in other regions.

The evaluation scope of work raises a very good question as to whether the HSSCS project would be better served to limit itself to improving MPHSAWC planning and coordination, and not become involved field support operations.

A possible advantage of the single-specific approach is that the project staff might be able to devote more time to, and hence be more effective in, the production of child survival policy and strategy, training and inventory documents, and studies of recurrent costs and sustainability. However, experiences in other countries have generally shown that single-purpose planning and management projects, without training, commodities and technical assistance components designed to strengthen service delivery, often do not receive the support of either the service providers or the service receivers. There is no incentive or motivation for these two essential groups to participate in planning and coordination because their most pressing problems are not dealt with. At least, this was the case with USAID-funded projects in Kenya, Swaziland, Ghana, Lesotho and Botswana.

The question of ensuring adequate staff time for PCU planning work is addressed in Chapters 4 and 5.

In theory one could argue for separation of planning and coordination from technical assistance for service delivery. However, due to the major constraints to child survival programs in Togo, the broad-based approach of programming conceptual and operational components jointly seems appropriate.

# 4.0 ANALYSIS OF STRUCTURAL QUESTIONS*

## 4.1 FINDINGS

### Position of the Government of Togo vis-a-vis the Planning and Coordination Unit (PCU)

The Government of Togo created the PCU through a ministerial decree dated November 23, 1987 (this followed the signing of the project grant agreement (ProAg) on September 7, 1987). Evidence of the PCU's direct attachment to the minister appears in Project Implementation Letter (PIL) No. 3 dated January/February 1988. However, the attachment was not confirmed by a ministerial decree.

On November 23, 1987, the GOT named the director of the HSSCS project as director of the PCU component. This person came from the Directorate General of Public Health and represents it within the PCU. He had neither training nor experience in planning and management, and had been named Director of the Maternal and Child Health (MCH) Division within the Directorate General of Public Health a month earlier (October 1987). Thus, simultaneously, he had to assume two important functions totally new to him. The many requirements of his operational position at MCH (including the direction of two family planning projects, one sponsored by USAID, the other by UNFPA) prevailed over those of his position as director of HSSCS and PCU, and the project suffered greatly as a result. To overcome this problem, PIL No. 3 of January-Feburary 1988 provided for the assignment at MCH of two service chiefs and an expatriate long-term advisor (financed by UNFPA). However, the expatriate advisor entered on duty only in March 1989, and a service chief for family planning is not likely to be recruited and trained before the end of the year. That leaves a service chief for maternal and child health to be recruited in order to complete the MCH Division team. In the meantime, unfortunately, the MCH director remains overburdened and unable to devote himself to the HSSCS project and the PCU.

Also on November 23, 1987, the GOT named two coordinators to the PCU. Their assignment on a full-time basis is confirmed in PIL No. 3, but this assignment has been more theoretical than real. The first coordinator, who had a certain amount of experience in project management and planning, was given the additional responsibility of supervising the activities of the third project component, community outreach. The second coordinator, loaned to the project by the Ministry of Plan, never really entered on duty. In fact, from October 1988 to July 1989, he was out of the country for demographic training. At the present time he is not back at his post in the PCU, and his future with the unit remains in doubt.

---

*This chapter is translated from the original French version.

The Advisory Board for Child Survival called for in the ProAg and composed of the three directors general of the Ministry of PHSAWC has never met, nor has the minister named its president. This board was to guide the definition and approve the content of policy and strategy statements, and of recommendations stemming from annual planning and budget exercises. The Advisory Board also was to use its influence to promote the allocation of GOT resources to child survival. The composition of the board corresponds to that of the Planning and Coordination Cell created within the MPHSAWC in 1988; that cell, too, has never met. At the tripartite meeting of January 15-17, 1989, which brought together representatives of GOT, USAID and DAC/MCD (the project contractor), it was recommended that the mandates of the Advisory Board be transferred to the ministry's Planning and Coordination Cell. The minister has not yet acted on this recommendation.

The project agreement also provided for a National Commission for Child Survival, a working group to be composed of all the entities of the ministries and other bodies participating in child survival activities, and charged with the following tasks: helping the PCU orchestrate collaboration among all the actors, facilitating exchange of information and experiences, preventing duplication of effort, determining common priorities, obtaining new funds, and guiding the allocation of recsources in accordance with the agreed priorities. The minister has not named a president for this commission and it has never met.

The tripartite GOT-USAID-DAC/MCD meeting recommended the replacement of the National Commission, which was deemed too cumbersome, with an Ad Hoc Technical Committee that would operate within the MPHSAWC and occasionally be enlarged to include other ministries, donors and non-governmental organizations. To date, the minister has not expressed himself on this recommendation, leaving the proposed committee up in the air.

Finally, it should be noted that the GOT, in accordance with its obligations, has made a strong financial commitment to the HSSCS project.

**Recognition of the PCU by its peers**

The recognition of the PCU by its peers, i.e., by the parties involved in the child survival sector, has suffered because of the conceptual/operational duality of the HSSCS project. In the eyes of observers (other donors, ministry divisions, etc.), the operational aspect of HSSCS has tended to overshadow its conceptual aspect. This misperception has been abetted by the incorporation into HSSCS of the personnel of the former USAID Rural Water Supply and Sanitation project (RWSSP), an operational project which had great visibility. Hence HSSCS is seen by many as the follow-on to the water supply project. The result is that even though the term PCU has been successfully implanted in

people's minds, it is used interchangeably to designate both the planning unit and the HSSCS project as a whole. This confusion is not something of recent origin; signs of it can be found in the project agreement itself. Moreover, PIL No. 3 uses the term "National Child Survival Unit" instead of "Planning and Coordination Unit." This supplemental name for the PCU cannot help but add further to the confusion.

The World Bank project with the ministry also has created a degree of uncertainty about the mission and position of the PCU. For one thing, this project includes a health and population cell which already is doing planning and coordination and will continue to do so in the future. This cell is currently attached to the Division of Public Hygiene and Health Promotion of the Directorate General of Public Health. For another thing, the cell is now working on a reorganization project for the ministry which envisages a planning, statistical and training function to be carried out either through a single unit for the entire ministry, or through a unit for each of the directorate generals. The place of the PCU in this scheme is not clear, not to mention the uncertainty that seems to have arisen over the scope of the PCU's mission: Should it be limited to child survival or be broadened to include all the programs of the MPHSAWC?

Contributing further to the confusion, the Combating Childhood Communicable Diseases (CCCD) project, which is attached to the Epidemiology Divison of the Directorate General of Public Health, also carries out child survival studies (in collaboration with the Health Statistical Service, a component of the Epidemiology Division). Moreover, certain donors, in particular UNICEF, have themselves taken the initiative to organize child survival planning exercises.

The final element of confusion is the creation in 1988 of the ministry's Planning and Coordination Cell. Its name is so close to that of the PCU that it is difficult not to see this as an intentional act. This has not, however, been confirmed officially. The only path open is the one recommended by the tripartite meeting of January 1989, namely, to make the PCU the operational and technical arm of the Planning and Coordination Cell.

**Connection with the Rural Water Supply and Sanitation project**

At the operational level, the transfer of the entire staff of the former RWSS project into the community outreach component of the HSSCS project has led outside observers and, to a certain extent, the transferred staff itself to believe that the former project is being continued. More than a year after the signing of the HSSCS project agreement, the community outreach component has neither designed nor undertaken activities other than those concerned with water supply. The ministry, and even AID (project WASH, based in Washington), continue to call upon the

considerable water supply expertise of the transferred staff, thereby maintaining the confusion both internally and externally.

The RWSS project was autonomous. The transfer of an entire staff from an autonomous project to a new project where they are called upon to participate in only one of three components has created problems of identity, adaptation and motivation which persist to this day.

In brief, the question of continuity and the loss of autonomy have led to significant tensions within the project team which explain in part the low level of achievement of the community outreach component in the area of child survival.

**Staffing**

On the Togolese side, the grant agreement provided for a director from the Ministry of Plan experienced in planning, and for two coordinators to be placed in the PCU, one representing Public Health, the other Social Affairs. It was also planned to have the latter coordinator supervise the community outreach component, and to have an expatriate assistant manage the implementation of the component's activities. The agreement says nothing about supervision of the health centers support component by the coordinator emanating from the Directorate General of Public Health. It seems that a Togolese assistant provided for in the agreement was to assume responsibility for this component and hence report directly to the project director. In the event, however, no Togolese assistant was hired. The person representing Public Health was named project director despite his inexperience in planning and management; and the person representing Plan was made a coordinator. The tripartite GOT-USAID-DAC/MCD meeting, incidentally, recommended that a coordinator representing the Directorate General of Women's Condition be assigned to the PCU. No such coordinator has been named to date, but the directorate general appears ready to participate in the project if that is the wish of the ministry.

On the technical assistance side, the community development technician, hired under a USAID personal services contract (PSC), has been in place since the beginning of the project. He is responsible for organizing, monitoring, coordinating and assisting the activities of the third component of the project, community outreach. The information/education/communication (IEC) specialist (under a DAC/MCD contract), who operates principally within the second component, health centers support, has been on duty since December 1988. The planning specialist (under a DAC contract), who serves as expatriate counterpart to the project director, assumed her position in October 1988.

At the present time, the members of the project team continue to seek their exact position in the project and in the PCU. There seems to be no job description or basis for evaluating the

performance of each team member beyond what one finds in the project agreement and in the contracts of the foreign counterparts.

## 4.2 CONCLUSIONS

### Position of the GOT vis-a-vis the PCU

Although it has allocated significant and adequate funds to the project, the Ministry of Public Health, Social Affairs and Women's Condition has committed itself to the PCU only with a certain reserve. This is evident from the naming of a director who has limited experience and who, above all, is already overburdened; the failure to name presidents for the Advisory Board and the National Commission for Child Survival; the failure of these two bodies to meet; and the lack of ministry reactions to the recommendations of the tripartite meeting of January 1989.

This stituation does not appear to reflect a lack of interest on the part of the ministry, especially if one considers the funds it has placed at the disposal of the project. More likely the problem results, on the one hand, from inadequate attention to the project owing to the excessive workload of the project director and of the cabinet to which he is attached; and, on the other hand, from the uncertainty which surrounds the placement of the planning function within the MPHSAWC and the means for carrying it out. It is impossible today to tell exactly when this uncertainty may be lifted by the creation of a planning directorate for the ministry, or of a planning division under each current directorate. However, the unresolved issue of restructuring should not be allowed to impede progress in the child survival sector. It has to be made clear to all concerned that the PCU, rather than being a hindrance to consolidated planning in the ministry, constitutes an embryo of a planning directorate or division in the specific sector of child survival, an embryo that can be integrated naturally into the planning structure which the ministry intends to put in place in the future.

To allay fears that the PCU will assume a broader mandate and more power than the various parties concerned are willing to concede to it at the present time, it is important on the one hand to remind these parties that the PCU's mission is aimed at child survival, and on the other hand to make clear that the PCU's attachment to the ministry should be interpreted as an attachment to the cabinet. In other words, the director of the PCU is a technician whose authority is strictly functional. Hierarchical authority is exercised by the minister and the director of cabinet. The PCU director is in a sense a planning advisor within the cabinet.

**Recognition of the PCU by its peers**

The PCU, in reality, is not recognized by its peers, i.e., by the directorates and divisions of the ministry, the donors, and the other parties involved in child survival activities. Evidence of this is found in the failure of the Advisory Board and the National Commission to meet, and in the lack of real and continued collaboration with the Epidemiology Division, the Health Statistics Service, the National Malaria Service, the pertinent services of the Directorate General of Women's Condition, the Health and Population Cell of the World Bank project, the CCCD project, UNICEF, etc.

This state of affairs is explained by the ambiguous status of the PCU director who is theoretically attached to the minister, yet is also attached, in his capacity as Director of the Maternal and Child Health Division, to the Director General of Public Health. It is further explained by the absence of a critical mass of planning expertise within the PCU, by the confusion surrounding the relationship of HSSCS with the former AID water supply project, and by the confusion of the PCU with the HSSCS project as a whole.

To obtain recognition for the PCU will require, first of all, that the ambiguity surrounding the status of the director be lifted by establishing his mandate exclusively with the HSSCS project. It will also require that the director be trained in planning if he has little or no expertise in this area; the same applies to the PCU coordinators, depending upon their need. Other steps required are: to have the two participants scheduled to receive foreign training under the project sent abroad quickly; to clarify, explain and sell the role of the PCU; and to eliminate the confusion of the HSSCS project, particularly its PCU component, with the former water supply project. This can be done by making clear, especially through field activities, that the community outreach component of the project is no longer concerned with pumps.

To avoid confusion between the conceptual and operational components of the project, it would be useful to give a name to the latter, for example, Operational Support Unit for Child Survival (OSU). This unit would comprise the activities of the two operational components of HSSCS and could perhaps be expanded to cover the activities of other projects (e.g., family planning) in the area of child survival. This might enable the unit to survive after termination of the HSSCS project. However, the institutionalization of an operational child survival unit does not figure among the HSSCS project outputs. What is called for, and is essential, is the institutionalization of the planning/coordination unit as a distinct entity or as part of a larger structure.

Now, as far as relations between the PCU and OSU are concerned, it is understood that the director of HSSCS is director of both the units. Nevertheless, to the maximum extent possible, he should delegate responsibility for community outreach to the assistant assigned to the component, and to the PCU coordinator from Social Affairs designated as its supervisor. The latter, however, like the project director, should devote the bulk of his time to the planning and coordination of child survival activities in a broad sense, not merely in the narrow sense of the operational components of the OSU. Of course, the PCU has planning responsibility for the OSU, but this responsibility is no different from that which applies to all other actions and projects in the area of child survival. This is also true for coordination. The project director and his expatriate counterpart, however, do have administrative responsibilities for OSU activities which they do not have for other child survival projects. Thus, the project director must pay particular attention to maintaining the complementarity of the two OSU components by ensuring that their respective programs are compatible and do not compete for the same resources (e.g., IEC) or engage in useless duplication of effort. However, on a day-to-day basis, it is up to the two assistants to ensure that operational activities are complementary and mutually reinforcing. Given the temporary character of the operational components of the project, the director should also systematically pursue the objective of permanently integrating their activities into the ongoing operations of the ministry (within the Health Education Service and the Community Development Division).

**Connection with the Rural Water Supply and Sanitation project**

It must be clearly established at this point that the RWSS project is not being and will not be continued through the HSSCS project, even if everyone, particularly the HSSCS project leadership, recognizes that rural water supply and sanitation are important to child survival.

This point established, it would have been much easier to achieve its acceptance by the transferred RWSS project staff if they had quickly been given alternative tasks to carry out in the area of child survival. The staff, however, was kept waiting for too long, a fact which helped dampen their team spirit. It certainly has been and remains proper to assert that conception must precede operations, but it is clear that when the operational team is ready to move and waiting impatiently, the conceptual staff has to give very high priority to those conceptual activities which must precede operations. Such high priority, unfortunately, does not appear to have been given.

**Staffing**

The intent of the designers of the HSSCS project was to create a critical mass in planning and coordination, a mass consisting of the project director and the two coordinators who were to devote the bulk of their time (say, at least three-quarters, to give an order of magnitude) to planning and coordination. The designers undoubtedly were made aware of the difficulties of finding Togolese outside the Ministry of Plan who were already trained and experienced in planning (which no doubt explains their proposal to have the director come from the Ministry of Plan). This led to the idea of having an expatriate counterpart provide the necessary training on-site. It was a fine scenario but did not work out because the foreign expert's arrival was delayed, and because the coordinator from the Ministry of Plan (intended in the project design to serve as project director) did not really integrate himself into the team; yet he alone among the Togolese, by reason of his experience, was in a position to offer training in planning to the project director and the other coordinator.

Now that the expatriate expert is in place, it is necessary to return to the original scenario; however, to make that feasible will require the presence of a critical mass consisting of:

- a PCU director who is truly available for the project, particularly for planning and coordination;

- a coordinator from Social Affairs who devotes most of his time to planning rather than to component No. 3, community outreach;

- a coordinator from Plan who is actually present in the PCU;

- a coordinator from Women's Condition.

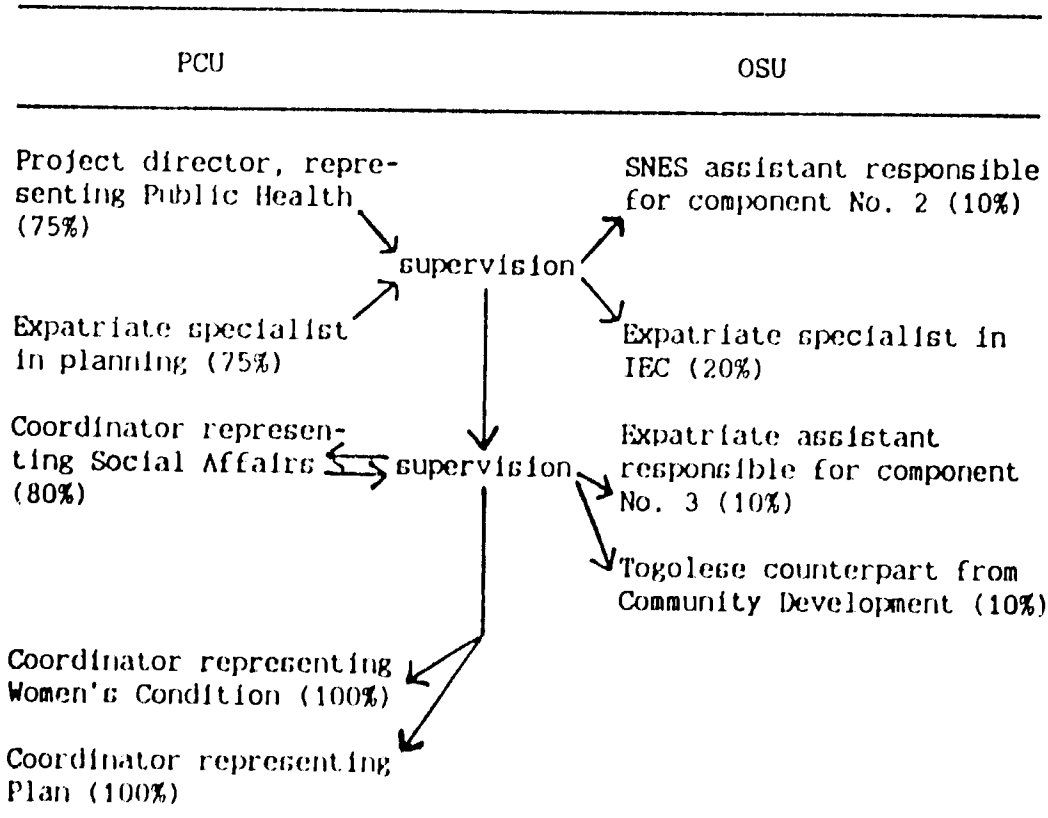
It is, of course, also essential that the expatriate advisor have sufficient time to design, initiate, coordinate and supervise the planning/coordination activities to be carried out by the four Togolese future planners in training at the PCU. On-site training for the PCU director and the three coordinators does not exclude the benefits they could draw from formal training abroad, but such formal training will be far more effective if it is preceded by concrete experiences in planning/coordination.

The project agreement called for placing component No. 2, health centers support, in the hands of a Togolese "teams' assistant." This assistant has not been hired because of the more or less generalized state of blockage in which the project finds itself. It would be advisable at this point to employ an assistant. To this end, and with a view toward institutionalizing the support activities, it would be desirable to have a staff member of SNES

serve in this function. He/she would thus serve hierarchically under the director of SNES, yet report functionally to the project director during the life of the project. He/she would be the Togolese counterpart to the expatriate IEC specialist. While these two persons could be based at SNES, they should maintain a foothold at project headquarters and be available there on a planned basis (for example, two half-days per week), both to offer their expertise in IEC to the PCU planners and the community outreach component, and to benefit in turn from the PCU's expertise.

With regard to component No. 3, the structure laid out in the project agreement is not particularly conducive to the transfer of knowledge and skills. In fact, the assistant responsible for this component is an expatriate who has no real Togolese counterpart (his Togolese supervisor knows more about the project than he does and is at too high a level to take over when it ends). In the interests of continuity, it would be advisable to ask the Community Development Division of the Directorate General of Social Affairs to delegate a Togolese counterpart who could prepare to take charge of the activities of component No. 3 at project termination.

To sum up, the project staff could be structured as follows (the percentages in parentheses correspond to the proportion of time that the different members of the project team should devote to the PCU, i.e., to planning/coordination):



**Effectiveness**

The PCU up to this time has not really been effective. The transfer of knowledge and skills from the foreign advisor to the director and the coordinators is not taking place because only one of the four Togolese is available. Few substantive planning and coordination actions have been undertaken. The PCU no doubt has succeeded in becoming involved in diverse planning and coordination exercises initiated since its creation, but the leadership has often come from elsewhere and the results of the exercises we were able to examine would need improvement.

The activities of the OSU also have advanced little outside of a community development action in the area of village water supply. This action is not strictly applicable to the HSSCS project, and could perhaps have been left to the Community Development Division of Social Affairs which, incidentally, receives substantial funds from the GOT for this purpose.

This ineffectiveness is related to a number of problems of which the principal ones are:

- non-availability of the project director;
- late arrival of his expatriate counterpart planning advisor;
- inexperience of the project director in management and planning;
- non-availability of the coordinator from the Ministry of Plan;
- difficulties in integrating the former water supply project team;
- unclear definition of the tasks and responsibilities of each team member;
- inadequate marketing of the project and the PCU;
- inadequate prioritization of project activities.

## 4.3 RECOMMENDATIONS - BASIC PRINCIPLES

1. The project director, representing the Directorate General of Public Health in the PCU, should have no duties outside of the project. He should devote at least 75 percent of his time to planning and coordination activities within the PCU, reserving the remainder of his time for direction of the overall project and the operational components.

2. The coordinator representing the Ministry of Plan in the PCU should work there full time and devote 100 percent of his time to planning and coordination activities.

3. The coordinator representing Social Affairs in the PCU should remove himself as much as possible from component No. 3 and spend

no more than 20 percent of his time on its supervision. He should devote himself essentially to planning and coordination on a broad scale.

4. In order to ensure equal representation in the PCU of the three directorate generals of the MPHSAWC, a coordinator representing Women's Condition should be named as soon as possible to be integrated into the planning/coordination team. The longer her nomination is delayed, the more difficult will be her integration and the more complicated will be the task of the expatriate expert in training her in planning.

5. The presence of a director and of three coordinators who devote the bulk of their time to planning/ coordination is essential to establishing the critical mass of planners that will finally enable the PCU to be recognized as a conceptual entity and to be effective.

6. The other members of the HSSCS project working in the OSU should be included in the PCU's activities. They, too, should contribute in a systematic way to planning and coordination activities. To ensure that the PCU and they benefit from participation in PCU activities, their contributions should not be left to chance but be planned and supervised.

7. The PCU must also systematically seek out similar contributions from the various divisions of the MPHSAWC, from other ministries, from donor organizations, etc., and must plan and supervise these contributions so as to secure maximum benefit from them.

8. All persons who contribute to the PCU, be they from HSSCS or from outside the project, should benefit from short-term training in planning if necessary, and from logistic support (secretariat, photocopying, documentation, office space, telephone, etc.) in the context of their work with the unit.

9. The expatriate planning expert should train the project director and the three coordinators in planning through in-house PCU seminars, and through concrete planning/coordination activities foreseen under the project, particularly the establishment and institutionalization of an annual planning and budgeting exercise involving personnel at the prefectoral and central levels. This is the most essential project output.

10. With respect to the in-house training, the expatriate expert should organize a planning seminar for the PCU team with the dual objective of providing basic knowledge and skills in planning and of welding the PCU staff into a team. To achieve the latter objective will require that the seminar be directed by the expatriate planning expert, be limited to the PCU director and coordinators, and be continued for a sufficient length of time

(say for one year, with a three-hour session every week or every two weeks). The training must be active and call upon the experiences of the participants.

11. The PCU, moreover, should be provided with documentation (books and reports) on the following subjects: planning, management and evaluation of health and social services; community development; IEC; and child survival. A budget should be prepared for this purpose. A simple lending system should facilitate access to these documents, which preferably should be in French.

12. Agreement should be reached with SNES to have it supply an assistant to take charge of component No. 2, support to health and social centers (a broadening recommended by the tripartite meeting of January 1989). A similar agreement should be reached with the Community Development Division of the Directorate General of Social Affairs for component No. 3, community outreach.

13. Formal training sessions abroad for the Togolese personnel of the PCU should be phased so as to avoid having the PCU lose its critical mass of planners over extended periods of time. Such training is desirable but not urgent, since it will be more beneficial if preceded by a period of on-the-job training. The overseas training could begin in the summer of 1990 with an intensive seminar in management and planning of health services. The possibility of long-term training for staff members should also be considered.

14. In addition, the plan to send two Togolese (other than the PCU director and coordinators) abroad for long-term training in planning and management should be implemented immediately by the parties concerned. The sooner the two persons are trained, the sooner they can return and replace the director and the coordinators while the latter undergo training abroad.

15. The PCU should use its own resources, including those in IEC, to make itself known. It is essential that PCU develop an image as a conceptual unit, distinct from the operational components of the HSSCS project.

16. The operational components of the project should also be publicized, and should no longer be concerned with rural water supply.

17. It should be made clear that the essential aim of the PCU is planning and coordination of child survival activities, and that the unit constitutes an embryo which can be integrated naturally into the broader planning structure that the ministry may put in place in the future.

18. The PCU should be attached to the cabinet rather than to the minister, so as to make clear that the PCU director's authority in the coordination and planning of child survival activities is strictly functional.

19. The attachment of the PCU to the cabinet should be confirmed by a ministerial decree.

20. The PCU director should report regularly on project activities (particularly those of the PCU) to the cabinet and to the president and members of the ministry's Planning and Coordination Cell.

21. The transfer of the mandate from the project Advisory Board to the ministry's Planning and Coordination Cell should be confirmed by the ministry.

22. It would also be desirable if the minister named the president and secretary of the National Commission for Child Survival, and if the commission met at least once a year.

23. The Commission should be seconded by a more flexible body called the Technical Ad Hoc Committee for Child Survival. It should be headed by the PCU director and meet every four months, or more often if required.

(See also the related recommendations and benchmarks at the end of Chapter 5.)

# 5.0 PROJECT PERFORMANCE RELATIVE TO PLANNED OUTPUTS AND IMPLEMENTATION SCHEDULE

## 5.1 FINDINGS

### Project Outputs

The project outputs as contained in the project paper are attached in Annex 1. They are reflected in less detail and, in part, less clearly, in the Amplified Project Description of the project grant agreement. If carried out in full, the outputs would constitute a giant step forward in enabling the Ministry of Public Health, Social Affairs and Women's Condition (MPHSAWC) to -- as stated in the project purpose -- "plan, manage, and coordinate the delivery of child survival services in a rational, cost-effective way."

Annex 2 contains the level of achievement on the major outputs as reflected in the latest six-month project implementation report (PIR) dated March 31, 1989. Of the 19 outputs listed, two are shown as 100 percent achieved: the establishment of the Planning and Coordination Unit (PCU), and the mobility of community outreach agents (continuing). Six outputs are between 6 and 10 percent achieved, and eleven are at zero percent. Since the issuance of the March 31 report, a month-long community mobilization training program has been conducted, raising that output from 6% to 31%.

### Implementation Schedule

A comparison between project actions taken and the implementation schedule contained in the ProAg (see Annex 3) reveals a similar pattern of significant delay. To note some highlights, the three Togolese counterparts were named shortly after signing of the ProAg, but only one of the three was available full-time. The technical assistance contract was scheduled to be signed in March 1988, with the health planner and IEC specialist to arrive on site in May. In fact, the PIO/T was issued in February 1988, the contract was signed in Washington in September, the health planner arrived in October, and the information, education and communication (IEC) specialist in December 1988. The agents' assistant for the community outreach component came on board in February 1988, but the teams' assistant for the health centers support component who was to be hired at the same time has not been engaged to date for lack of sufficient activity.

Until October 1988, accomplishments consisted essentially of the assignment of the Togolese counterparts, the transfer of the capital assets and personnel of the Rural Water Supply and Sanitation project (RWSSP) into the Child Survival project for the community outreach component, the contracting of the

agents' assistant for that component, preparatory planning for the various components, the procurement and initial equipping of unit premises, and the organization of the office. Substantive project activities picked up steam with the arrival of the TA team. The semestrial report and the project implementation report for the period October 1988 - March 1989 (see extract from the PIR in Annex 2) reveal a wide range of planning, technical and operational activities carried out under the three components. An important activity promoted by the PCU -- originally planned for April 1989 but repeatedly postponed, most recently because it was not properly cleared within the ministry -- is expected to occur in September or October. This activity is a major seminar to discuss policy, strategy and work plans for the National Health Education Service (SNES) and to assess its personnel and material needs. However, this and prior activities constitute only a beginning. Overall, the project, now ending its second year, is approximately one year behind schedule.

Reasons for Low Output Achievement

Much of the explanation for the low rate of output achievement and slowness of action can be found in the previous chapter dealing with deficiencies in project structure and status within the government, in status within the donor community, and in personnel configuration. The following expands on that analysis and cites additional reasons.

Non-availability and limited experience of two of the three assigned counterparts. The project has suffered from the absence or near-absence of two key Togolese team members. The director, whose previous post was as chief pediatrician in a regional hospital, has sought to give direction to the project through participation in key meetings and the development of an annual work plan. However, he lacks broad administrative and planning experience and holds other major responsibilities such as director of the ministry's Mother and Child division and director of the AID and UNFPA family planning projects. His presence at project headquarters has been highly sporadic and limited. This situation is contrary to what the project agreement envisioned: an experienced, full-time director. The coordinator from the Ministry of Plan was assigned to head the health centers support component (the original idea was to have this coordinator come from Public Health and the director from Plan -- precisely the reverse of what happened). However, the coordinator absented himself for training in demography for ten months and has never fully participated in project activities. He returned from training during the evaluation and within a few days went on vacation. These absences have left the expatriate health planning advisor, who is the contract chief of party (COP), almost alone to provide planning, technical and administrative oversight; she has devoted very long hours to the effort.

**Low Morale and Inadequate Team Cohesion.** Morale within the talented group of project personnel is low and their team spirit is weak. They feel the project is moving at a snail's pace, largely because the PCU lacks credibility within the government and the donor community, the health centers support component has barely begun, and the director has been too preoccupied with other activities to provide timely leadership and follow-through on policy and administrative matters. The COP, who displays a keen grasp of the objectives and potential of each project component and has a wide range of contacts, has tried to compensate for the absence of the director, but without the benefit of a director's authority. She has sought internal cohesion largely through consensus-building, but with mixed success. It has taken until now to achieve a consensus between the COP and the community outreach group on the timing and need for technical planning before health education activities are carried out. However, the community outreach coordinator, who is the third Togolese counterpart, has been cooperative and diligent and effectively manages his component; he was previously the director of the RWSS project. The agents' assistant, who is under a personal services contract with USAID, works closely with the latter, is very knowledgeable, and is now well-integrated into the overall project. Initially, he had difficulty making the transition from his duties under a previous PSC. The IEC specialist is a highly competent communicator who has established his credentials with his prime counterpart agency, SNES. (This took some effort, because SNES has been slow to accept the project and its operational objectives). However, he has not fully coordinated his activities with the rest of the project staff. Finally, the aforementioned coordinator from the Ministry of Plan operates with total independence, essentially divorced from the project.

**Salary supplement issue.** Morale is further reduced by the unfulfilled desire of the senior Togolese project staff for USAID-financed supplements to their low government salaries. The justifications cited by the two of the three staff members who raised the issue with the evaluation team are (a) the demanding nature of their project assignments, leaving little or no time to seek outside income, (b) their detachment from their normal civil service functions, and (c) in at least one case, the risk that this detachment poses for his career ladder.

The supplement issue has been on the table since the outset of the project. USAID submitted a request to AID/Washington in October 1988 for authorization of the supplements. These would represent a significant percentage increase over the salaries in question, but would be modest by comparison with some local non-GOT salary levels. Several issues remain to be resolved with Washington, including submission of a Togolese legal opinion confirming the statement of the GOT Civil Service director that salary supplements are permitted under Togolese law; and a determination of the importance of the supplements

to the achievement of project objectives. If the supplements are finally approved by Washington and USAID, the latter would seek the PHSAWC minister's approval before implementing them. Judging by what the team learned during its interviews with the personnel concerned, if the supplements are approved, it is not certain how adequate they would be considered; and if they are rejected, the reaction would certainly be disappointment. In either case, it is difficult to say whether the affected personnel would decide to remain with the project and give it their full, devoted effort, or leave for possibly greener pastures or less demanding assignments elsewhere.

**Delayed approvals.** Actions often remain in limbo for lack of clearance or approval from other offices. Several planning and training sessions were held up for many weeks because a USAID review of local per diem policy led to the misunderstanding that the project could not pay per diem until the review was completed. Terms of reference for a major planning/budgeting seminar to be carried out under contract with a U.S. university were prepared by the COP in May 1989, but have not yet been approved by the USAID project officer. As noted earlier, the Minister of Health, Social Affairs and Women's Condition has not responded to a series of major recommendations on project structure and responsibilities formulated at a tripartite meeting in January 1989 of GOT, USAID and project representatives. The project director transmitted the recommendations of the meeting to the minister on March 1. The USAID Representative followed up with a detailed letter on May 3 which remains unanswered. The non-response probably resulted in large part if not entirely from the confusion and reticence discussed in the previous chapter. A fourth example of delay is mis-communication with the ministry on a USAID request for candidates for two long-term training grants under the project. The request was initiated in August 1988; a final list of candidates remains to be proposed by the ministry. It may prove difficult to place the participants for the 1989 fall semester, and possibly for the January semester if their English is inadequate. Finally, during the evaluation the project director became ill and was ordered by his doctor to go home for two weeks' rest. He was not bed-ridden. As of this writing, he has failed to delegate any authority, yet has refused to attend to any urgent business or pay any bills except -- after a week's delay -- staff paychecks.

**Complex planning environment.** Contrary to the implicit expectation of the project designers, the project did not take over the controls of a planning and coordination "train" that was stalled or barely moving. Rather, the project found itself having to run to jump on board, and is still struggling to reach the locomotive. A planning process for child survival, or rather a series of processes, already exist in Togo. With UNICEF and WHO in the lead, international and bilateral donors set the tone each year or every few years for the latest child survival themes and specific projects, and engage the government in a variety of initiatives which may or may not be

coordinated and may or may not be of priority value for Togo. There is no question that the GOT needs to gain control of this ad hoc state of affairs through a planning and coordination mechanism that will systematically analyze various child survival program options -- a process of the type which the project being evaluated seeks to offer. But the dynamics of the ongoing, scattered planning process, abetted by a highly vertical structure of services within the MPHSAWC, makes it a significant challenge for the project to gain a foothold. Fortunately, major donors such as UNICEF, UNFPA and FAC (French aid) recognize the need for, and state they would welcome, an effective Togolese planning and coordination unit. In fact, both UNICEF and FAC have indicated they would respond positively to requests for assistance to the PCU. Hence, if the PCU can establish its credibility as a recognized entity that knows what it wants and has the core staff and means to attain it, the existence of cooperative donors should enhance rather than hinder the PCU's effort to take charge of the planning/coordination locomotive.

## 5.2 CONCLUSIONS

The consequence of the above factors is that the three components, while scoring some individual achievements, have operated with limited coordination, timeliness and effectiveness as a combined project entity. Transfer of technical knowledge and skills has been minimal. If the project continues on its present uncertain course and at the same painfully slow pace, it is doubtful that anything of lasting developmental value will be achieved, throwing into question the utility of the financial and human investment in the project made by both USAID and GOT. The evaluation team's doubts apply particularly to the planning/coordination and health centers support components. The community outreach component is in slightly better shape because of full-time, experienced management and an established modus operandi inherited from the RWSS project.

Two of the problems cited under "Findings" -- salary supplements and responsiveness to action requests -- merit further discussion, not because they are more important than the other issues, but to highlight certain aspects and conclusions.

### Salary supplements

This is a thorny issue. On the one hand, the GOT counterparts' government compensation is low and they work in close proximity with TA staff who receive higher pay comparable to what they might earn in their home countries. Moreover, other donor projects in Togo frequently pay supplements. On the other hand, the evaluators find problems with the USAID justification for the supplements in light of strict AID criteria and specific project requirements. A key AID criterion for payment of supplements is that the recipient

offer special skills that might be lost to other projects if compensation is not competitive. However, as discussed in the chapter on structure, a major task of the project henceforth will be to train the counterparts in planning and coordination techniques. Hence, while the counterparts may bring high-level skills to the project in some areas, in this major category they will benefit from learning new skills and applying them in what should be a career-enhancing environment. The USAID is in the best position to judge the scarcity in Togo of the skills which the three counterparts currently do offer.

With respect to specific project requirements, the mission's justification rests in part on the important additional responsibilities which the counterparts hold or may hold outside the project and which are of direct interest to AID's overall program. This justification contradicts the intent and necessity of the project to have the counterparts engaged full-time on the Child Survival project. The justification might be better centered on the full-time requirement and the role that salary supplements might play in this regard.

An important point is whether the provision of salary supplements hinders project sustainability or has no impact thereon. USAID's authorization request states that "any continuation of the project beyond the initial three operational years would require the integration of the PCU into the MPSAWC organizational structure and there would be no exceptional basis for payment of salary supplements." This is correct. But if that integration depends upon continuation of the services of those trained under the project, are they likely to stay on if they received supplements under the project, or are they more likely to look for other jobs offering the higher pay to which they will have become accustomed? The answer that the evaluators received was that supplements could be furnished with the clear understanding by the recipient and the ministry that the former would continue service in health planning upon project termination.

As noted under the findings above, if the salary supplements are rejected, the counterparts will be disappointed; and if they are approved, they may or may not be considered adequate. The important thing, in the evaluators' view, is that a decision be made soon. Once the issue is settled one way or the other, the counterparts can determine their course of action. If any of them decide to leave the project, a replacement or replacements can be sought on the basis of firm knowledge of the project policy on supplements, and of the substantial professional benefits which participation in a project introducing systematic health planning may bring.

A decision to grant supplements would constitute a new commitment by USAID. Any new commitment, whether large or small, implies confidence in the future of the project and calls for a counter-commitment. USAID confidence should be

based on (a) USAID's conviction that the project is truly being "unblocked" per the recommendations for ministry and project action listed at the end of this chapter, and (b) that the proposed recipients of the supplements have demonstrated their commitment to the reforms by a period of full-time, professional performance. In other words, supplements are to be earned through proper performance, not serve as a precondition for it. There is certainly no basis for complying with any request for retroactive payment of supplements, given the minimal presence to date of two of the counterparts.

**Responsiveness to action requests**

The project, the ministry and USAID can greatly improve efficiency by being alert to delays in processing actions and clearances, and to call such delays promptly to the attention of the office causing the problem. If any procedural or technical disagreements are the cause of delays, it is incumbent upon the personnel concerned to seek prompt resolution of the differences; to let them fester can only cause further delays and complications in a project that already has a surfeit of them. It is also essential that the project director establish delegations of authority so that urgent business can be transacted in his absence.

## 5.3 RECOMMENDATIONS

**Introduction**

The project has major structural and organizational problems identified in this and the preceding chapter, problems which have severely hampered efforts to move the project forward. A serious effort to solve these problems needs to be launched before evaluators can assess the potential of the project, as now designed, to achieve its planned outputs and purpose. The following recommendations, building upon the principles laid out in the previous chapter, are intended to help all concerned break through the logjam.

1. Mini-evaluation. Based on the recommendations below, which are designed as benchmarks for action between now and November 30, 1989, it is recommended that USAID, GOT and one or two representatives of REDSO/WCA organize a mini-evaluation in early December 1989 to assess performance and determine next steps. It should be stressed that the benchmarks do not represent all the activities which the project is expected to carry out during this period. Rather they are deemed fundamental actions necessary to permit the planning and operational activities of the project to proceed normally and productively.

The terms of reference for the mini-evaluation should at a minimum include the following:

a. Assess the timeliness and effectiveness of performance in meeting the benchmarks.

b. Determine whether the quality of performance in ongoing, "non-benchmark" activities improved in response to the guidelines and recommendations of this evaluation as a whole.

c. Evaluate the factors which permitted or hindered success in meeting the benchmarks, including the level of commitment displayed by each member of the project team, the USAID and the MPHSAWC.

d. Determine whether progress was sufficient to warrant continuation of the project or of all of its components, applying the criterion of an adequate and timely developmental return for the investment of USAID and GOT resources. If it is deemed that progress was insufficient and that continued investment would yield an inadequate return, consider immediate termination of the project, or of deficient portions thereof.

e. If continuation of the project or of certain of its components is deemed appropriate,

- determine the need for any changes in organization, personnel assignments, scopes of work, procedures, inputs, outputs, budgets, schedules and length of project, and

- review the project workplan and set further benchmarks.

Following are the benchmarks for the period until November 30, 1989:

2. Attachment of PCU to the ministry's cabinet. Pursuant to recommendations 18 and 19 in the previous chapter, the Minister of Public Health, Social Affairs and Women's Condition signs a decision document in August 1989 attaching the PCU to the ministry's cabinet, and naming the director of the Child Survival project and of the PCU as a technical advisor on a full-time basis with functional responsibility for coordination and planning in the area of child survival. This action will clarify Decision No. 283/87 of November 23, 1987 which established the PCU and named its members without specifying their location within the ministry; and will confirm PIL No. 3 (USAID/Togo letter No. 88/019) of January/February 1988 signed by the Minister and the USAID Representative which established the unit close to the Minister's office.

3. **Tripartite meeting recommendations.** The Minister responds to the recommendations of the Tripartite Meeting held in January 1989, which were submitted to him for consideration in March. One difference between the recommendations of the evaluators and those of the Tripartite Meeting should be noted: the evaluators believe that the Ad Hoc Committee should support the work of the National Commission, not replace it (see recommendations 22 and 23 in the previous chapter).

4. Ad Hoc Technical Committee. Pursuant to recommendation 23 of the previous chapter, the Ad Hoc Technical Committee for Child Survival meets at least once before November 30 and sets a date for the next meeting within approximately four months. This presupposes the Minister's action on recommendation 3 above and on recommendations 21 and 22 of the preceding chapter relative to establishment of the Advisory Board and the National Commission.

5. **Full-time availability.** The project director and the three coordinators of the PCU (including the new coordinator from the Directorate General for Women's Condition who should be assigned by September -- see recommendation 4 in the previous chapter) are available and functional on a full-time basis within the project.

6. Director's profile. The project director demonstrates knowledge and experience in planning, or a readiness to learn on-site with the assistance of the expatriate advisor. He also demonstrates leadership by motiviting the project staff individually and as a team, communicating effectively, making timely decisions, establishing and pursuing priority activities in cooperation with project staff, and organizing and administering the office on an efficient basis, with delegations of authority to make urgent decisions in the director's absence.

7. **SNES and Community Development personnel assignments to the project.** SNES and the Community Development division each assign one of their experienced staff members to serve full-time as assistants under operational components 2 and 3 of the project, respectively.

8. SNES seminar. The long-planned seminar to discuss the policy, strategy, plans and operational needs of SNES is held, laying the foundation for (a) a close and active working relationship between SNES and the child survival project, especially the IEC advisor, (b) the training, mobilization and equipping of the health education teams at an early date, and (c) involvement of the Peace Corps in the teams' effort.

9. Salary Supplements. USAID and AID/Washington make a decision on salary supplements and communicate it to the personnel concerned as soon as possible before November 30. Essential criteria for a positive decision would be (a) evidence of substantial progress in "unblocking" the project

per this list of recommendations, (b) evidence of the proposed recipients' full-time, professional commitment to making the project a success, and their commitment to remaining active in GOT health planning after the project ends, and (c) approval of the Minister.

10. Work plans. Based on an analysis of child survival needs and problems, the project staff prepares detailed work plans for a minimum of six months for components 1, 2 and 3 of the project, setting forth clear priorities, objectives, methods and procedures, planned outputs, and needed resources.

11. Internal planning seminars. Pursuant to recommendation 10 in the previous chapter, the PCU members organize and in October begin holding weekly sessions of an internal team seminar on planning under the direction of the health planning advisor. As evidence of seminar performance, the mini-evaluation group should have at its disposal the seminar plan and objectives, a list of the subjects addressed, a collection of the initial set of readings, the teaching methods utilized, and a description of how knowledge acquisition by the team members is measured.

12. Long-term training. Pursuant to recommendation 14 in the previous chapter, USAID and the Ministry select two Togolese for long-term training in August, with the training to begin at the earliest possible date.

13. Planning/budgeting seminar. USAID, the health planning advisor and her counterparts in the PCU agree in August on terms of reference for the first of two in-country planning/budgeting management seminars called for in the project, and take steps to have it contracted and organized as soon as possible.

14. Recurrent cost plan. In accordance with Section 4.2 (a) of the project agreement (see Chapter 8), the project team and the ministry prepare for USAID concurrence a detailed plan for GOT's assumption of the costs of petrol, oil, lubricants, and repairs for the motorcycles used by teams and community agents so that these groups retain their full mobility after the project ends.

15. Project marketing. Pursuant to recommendations 15 and 16 in the previous chapter, the project puts in place a marketing plan for publicizing the responsibilities and capacities of its components. The plan stresses (a) the existence of the PCU as an integral ministry function rather than as a temporary USAID project, and (b) its distinction from the project's operational components, especially community outreach. END OF BENCHMARKS.

16. Suspension of reporting requirements. Because of (a) the heavy demands that the above set of recommendations will place on the project team, and (b) the availability of

this in-depth report and the availability in December or January of the mini-evaluation team's report, it is recommended that USAID, AID/W, the ministry and the contractor reduce to a bare minimum the progress reporting which would normally be required between now and January 1990.

# 6.0 OTHER PROGRAM AND TECHNICAL ISSUES

Following are discussions of program issues raised in the evaluation scope of work which have either not been treated in previous chapters or require additional treatment.

## 6.1 Appropriateness of project objectives and their timing, and of combining conceptual with operational activities.

### 6.1.1 FINDINGS

As stated in Chapter 5 on project performance, the project is approximately one year behind schedule. The reasons have nothing to do with the appropriateness of the project objectives and their timing or of combining conceptual with operational activities, but rather with unanticipated structural and management constraints that have resulted in a near-logjam on performance. It may have been unrealistic for the project designers to expect a totally smooth and rapid start to a project seeking to introduce a new planning system at the heart of a complex ministry, not to mention the usual delays in processing contracts and hiring technical advisors. However, the extent of the problems encountered on-site was probably not predictable.

The volume of project objectives may be unrealistically high for the few years available to the project. However, in the absence of a viable project structure and of key staff members to pursue any objectives at a normal pace, the evaluation team was not in a position to assess the potential realism and appropriateness of the objectives as a whole.

Several outputs, however, stood out as probably warranting review. These are the outputs calling for a ten-year national child survival policy and strategy paper, annually updated five-year child survival plans and budgets, and an eight-year child survival training plan and budget. Given the nascent state of health planning in Togo, both within the government and in relation to donors with changeable policies and programs, the time spans may be too long to allow for realistic, meaningful projections that will be respected and used by GOT and donor planners.

### 6.1.2 CONCLUSIONS

Because of the constraints blocking performance, a full assessment of the appropriateness and realism of the objectives, the combined approach, and the timetable is not possible at this time. Chapter 3 concludes that the project design combining operational and conceptual components is

theoretically sound. The recommendations in Chapters 4 and 5 for additional Togolese personnel to be attached to the operational components, and for the senior personnel to become full-time team members and devote the bulk of their attention to planning and coordination, are designed to facilitate simultaneous action on the planning and operational fronts.

The mini-evaluation proposed for December 1989 will be in a better position to determine the appropriateness of the objectives, the combined conceptual-operational approach, the achievement timetables, and a possible extension, once the project team, the MPHSAWC and USAID have had a chance to clear the blockage, in accordance with the recommendations/basic principles in Chapter 4 and the benchmarks in Chapter 5. If the mini-evaluation determines that the blockage is cleared but that design revisions are required, they should be undertaken without delay.

With regard to the issue of planning horizons, one approach might be to work up from short-term plans to longer ones as the planning and coordination process takes root.

**6.2 The appropriateness of excluding child survival service provision from the project.**

6.2.1 FINDINGS

The project in its operational components provides support to service providers in the form of IEC training, health education, training in health planning, motorcycles and gasoline for field agents, etc. The project does not provide direct services to the population such as vaccinations, chloroquine and ORT supplies. The evaluation team received no indication from numerous interviews that there was any interest in having the project provide direct child survival services.

6.2.2 CONCLUSION

Since other AID projects and donors such as CCCD and UNICEF are providing substantial direct child survival services to the population, it would only be duplication for the HSSCS project to do likewise. To add service provision would be to burden the small project staff with an entirely new set of operational responsibilities, detracting from its mission to provide planning and coordination assistance and operational support services.

**6.3 Is the project focus sufficiently defined? Is the PCU getting spread too thin on technical issues to the detriment of planning? Does it make sense to limit planning improvement to child survival?**

### 6.3.1 FINDINGS

**Focus definition.** Child survival involves several areas of intervention on which there is general agreement among the donors and African countries, including Togo. However, the boundaries of child survival policy may be somewhat blurred in Togo, if not elsewhere as well. The PCU is working within this framework, participating with GOT services and other donors in defining specific CS policies and technical protocols.

**Planning and technical issues.** These overlap to a considerable extent, making it difficult to draw a clear line between the two. A degree of involvement in technical reviews is necessary to plan the exact nature of health service interventions and health education messages, matters of direct concern to the two operational components of the project.

**Scope of planning.** Overall health planning is beyond the current scope of the project, and is the focus of a separate program design which has long been in preparation for submission to the World Bank. No one interviewed by the evaluation team suggested that there was any conflict between child survival and general health planning, or that the PCU should broaden its mandate. At the same time, there are situations where it is impossible or inadvisable to draw an arbitrary line between child-survival and other types of health planning and budgeting. For example, regional health budgets do not separate child survival from other aspects of health services, and CS planning must necessarily take account of the overall health planning environment.

### 6.3.2 CONCLUSIONS

**Focus definition.** The PCU staff cannot ignore any of the recognized areas of intervention for child survival. What it can do is help the GOT and donor community develop priorities -- for example, in the form of consecutive rather than simultaneous emphasis on various interventions. In this way the GOT health system will not suffer from overload -- trying to do everything at once with limited financial and human resources.

**Planning and technical issues.** The PCU staff should exercise careful judgment to limit its participation to issues directly affecting policy and the implementation of operational projects, including the health centers support and community outreach components of the HSSCS project. By avoiding participation in meetings of minor relevance to the project, the small PCU staff can concentrate on priority and long-term objectives.

**Scope of planning.** The project should not expand its mandate. If and when a broader health planning structure is put in place, the PCU should be incorporated into it. At the same time, the PCU should not be rigidly confined to the point where it cannot deal with issues and practices in the larger

budgets in preparing its analyses and making judgments on priority needs. If it determines that additional studies are needed, it can approach CCCD, other donors, and the GOT's National Health Statistics Service to provide assistance.

With respect to project benchmarks, little baseline data collection appears necessary to establish the current level of planning capability. A brief description of existing mechanisms and procedures should suffice. Every institutional advance in child survival planning and coordination within the government and with donors that the project brings about should be readily apparent at project termination.

The project will also need a list of current indicators for the GOT's organizational and logistical capability, centrally and in the field, to manage the training and outreach activities, and a set of achievement benchmarks.

For the operational components, one could measure KAP impacts within the following groups and areas of interest:

| | Target Groups | KAP Survey Areas |
|---|---|---|
| Component No. 2 | 2.1 42 SNES agents<br>2.2 1700 agents of directorates of PH, SA and WC | Problems of child health<br>Child survival techniques<br>Communication techniques<br>Community relations |
| | 2.3 Gen'l population | Problems of child health<br>How to respond to problems |
| Component No.3 | 3.1 120 community agents<br>3.2 1,000 village development committees (VDCs) | Problems of child health<br>How to respond to problems<br>Applicable home techniques<br>Communication techniques |
| | 3.3 Gen'l population | Same as above except for communication techniques |

Project impacts can theoretically be measured in any group and in any area of interest through before-and-after KAP surveys. In the case of the two operational components, one might wish to concentrate on the third group in each, that is, the population, since that is ultimately the group whose KAP the project seeks to change. However, since large-group surveys are costly and difficult to accomplish, it would be preferable to concentrate on the intermediate target group 2 in each project component, and to do so on a sample basis in order to limit cost.

health sector that impact on child survival. Moreover, the developers of the larger health planning structure can benefit from the experience of the PCU, and the PCU ultimately should be incorporated into it. In fact, the project paper calls for the project to train ministry personnel in overall health planning.

## 6.4 Collection of baseline data and establishment of benchmarks for measurement of project progress

### 6.4.1 FINDINGS

Baseline data for this project takes three forms: current indicators for child survival in Togo; the GOT's current level of capability to plan and implement child survival activities; and knowledge-attitudes-practices (KAP) data on the beneficiary population. Togo already has a wealth of data in the first two areas superior to that of most African countries. The CCCD project and the GOT's National Health Statistics Service have played a leading role in compiling available statistics in both areas and in preparing time series to permit trend studies. The result is an impressive book published in May 1989 entitled, "Statistiques Sanitaires 1988."

Information not provided by this study is data on the GOT's institutional capability to manage the activities of the project's two operational components, and before-and-after KAP data on the trainees and villagers benefiting from these two components. With respect to the planning and coordination component, however, the baseline is essentially a clean slate; child survival planning takes place in a very scattered fashion within the government and with the donors.

Other than studies on pump utilization and maintenance in the former Rural Water Supply and Sanitation (RWSS) project zone, which is also the current project's zone for community outreach, the project has not carried out baseline studies or made systematic use of available statistics as a basis for overall child survival planning. The understaffed PCU has devoted the bulk of its time to participating in program-by-program and policy-by-policy reviews and planning sessions with the GOT and other donors.

### 6.4.2 CONCLUSIONS

The PCU needs to complete baseline surveys and needs assessments for its activities in planning, training, communication and management. Systematic use of data also will facilitate horizontal planning across the spectrum of child survival activities, including resource analysis, studying of alternative responses to health problems, and setting of priorities for implementation.

The PCU can take advantage of available statistics on current health indicators, GOT health service personnel and health

### 6.4.3 RECOMMENDATIONS

1. The PCU, once strengthened per the recommendations in Chapters 4 and 5, should develop a data base that will allow it to (a) focus its broad-scale planning efforts more along horizontal than along vertical, program-by-program lines, in order to establish priority objectives, and (b) assist in planning, implementing and measuring the progress of all HSSCS project activities. To these ends, the PCU should

a. take full advantage of available statistical data and other studies in performing its analyses and in training its own staff in planning,

b. request other baseline studies it needs from appropriate sources, undertaking such studies on its own only if absolutely necessary,

c. prepare a brief description of the present government and donor planning/coordination process in the area of child survival.

d. compile indicators of the GOT's current organizational and logistical capability to carry out components 2 and 3 of the project,

e. prepare benchmarks to measure institutional progress in all three components, and

f. undertake before-and-after KAP surveys on a sample basis among the agents and village development committees who are closest to the target population.

To avoid burdening the limited staff resources of the project, short-term consultants might be hired to help compile baseline data and set benchmarks per items d., e. and f. above.

## 6.5 Other technical issues

### 6.5.1 FINDINGS AND CONCLUSIONS

The bulk of this evaluation has focused on issues of structure, organization and personnel, since these have caused the major constraints to implementation. This section, along with Sections 6.3 and 6.4, deals with technical issues which will take on increasing importance as the project hopefully overcomes its structural constraints.

PCU has participated in a number of planning exercises with GOT and other donors. However, it was difficult for the evaluation team to identify the precise role played by PCU. The unit should document its contributions to the definition and

development of various policies and programs, e.g., through position papers and proposals. This should be easier to do once PCU plays a more prominent role in planning and policy development.

PCU has collaborated with UNICEF on issues related to cost recovery, self-financing and sustainability of child survival programs in Togo. This issue warrants major attention by PCU in the future.

Two points may be noted about data for the community outreach component: (a) creation of good control systems to identify cost/benefit data is a prerequisite for attempts to develop a replicable project. This was not done under the RWSS project, but should be done under HSSCS. (b) An improved reporting system for the component is needed. Its focus should be to develop a national system of village-level data collection and analysis to enable district medical officers to quantify health problems, establish priorities, focus interventions on target groups, and monitor the effectiveness of interventions and the use of health services by the rural population.

### 6.5.2 RECOMMENDATION

2. As part of its technical work, PCU should regularly document its contributions, emphasize cost recovery, and develop cost/benefit and village-level health data for its community outreach component.

## 6.6 The degree to which women are able to avail themselves of project benefits and participate in project activities.

### 6.6.1 FINDINGS

Given the fact that women in Africa bear a far greater responsibilitry than men for infant and child care, any project that provides means to improve child survival will be of direct benefit to them. Women are active members of the village development committees, and hence are in a position to play leading roles in transmitting health education messages at the local level.

An example of women's participation in which AID/AFR has expressed particular interest is women water pump caretakers. These people were trained under the predecessor Rural Water Supply and Sanitation project to oversee pump use and maintenance, identify repair needs, call upon repairmen when necessary, and ensure hygienic practices in the immediate pump area. Each of some 1,050 village development committees (VDCs) supplied with a pump under RWSSP has such a person. However, a survey undertaken by the HSSCS project has revealed that, two years after completion of RWSSP, about 37 percent of the pumps are broken down. Also, VDCs and women caretakers in 350 villages were trained in 1987 in the operation and maintenance

of one type of pump, whereas in 1988 a different type of pump was installed. Hence retraining is necessary in those villages both because of the time lapse between training and pump installation, and the difference in pump types.

Because of the importance of clean water to health, the HSSCS project is planning to provide refresher training to the 350 VDCs and the women pump monitors, but will leave technical training of pump repairmen to others. In this regard, it is noted that the Directorate of Social Affairs had 10 million and 15 million CFA, respectively, allocated in 1988 and 1989 for "Programme socio-sanitaire USAID," i.e., RWSSP. This would appear to be a commendable follow-on to RWSSP, allowing for such expenditures as repair and retraining; however, the HSSCS project staff has not learned how the money is being used.

Future plans, more directly related to health education, call for the creation of health subcommittees under each VDC with a man and a woman jointly placed in charge. Such joint responsibility is considered more effective than depending upon a man or a woman alone to promote correct health practices.

With regard to women's participation at other levels, approximately ___ percent of the agents of SNES and of Social Affairs services who are or will be trainers and trainees under HSSCS are women. There are very few women in positions of responsibility at the central level who would benefit from the project.

### 6.6.2 CONCLUSIONS

The HSSCS project by its very nature targets women as beneficiaries. For this reason, the project should promote women's participation at every level. To this end, Chapters 4 and 5 contain recommendations to bring into the PCU a coordinator from the Directorate General of Women's Condition (for lack of female staff the coordinator may turn out to be a man, but his mission will be to represent women's interest in planning and coordination).

The project's attention to women at the VDC level is commendable. However, in order to maintain clear lines of responsibility and in view of the HSSCS project's limited resources, the community outreach component henceforth should concentrate strictly on health education and related community mobilization, leaving matters of pump maintenance and training to the Directorate General of Social Affairs.

### 6.6.3 RECOMMENDATIONS

3. Once the coordinator from the Directorate General of Women's Condition is assigned to the PCU, she or he should examine the role of women in the project both as beneficiaries and as participants, to determine how the project may enhance both roles. As needs are identified, USAID should request

AID's WID office to provide needed assistance such as current applicable literature (if possible in French), names of consultants, and possibly consultancies from its own staff.

4. Given the importance of water sanitation to village health and the substantial investment by AID and other donors in the RWSSP, USAID should (a) seek information on what the GOT and/or other donors are doing to ensure pump maintenance, and (b) take any further steps it deems appropriate in this regard. This recommendation should not be interpreted as a suggestion to reopen the AID water supply project.

## 6.7 Effectiveness of the PCU in coordinating child survival activities among different donors, including USAID.

### 6.7.1 FINDINGS

The PCU has taken a number of initiatives to coordinate its work with other donors. Soon after her arrival, the chief of party paid calls on the heads of donor agencies and NGOs operating in the child survival field. In December 1988, the PCU in conjunction with UNICEF, WHO and CCCD organized the first annual planning exercise for central-level officials of the Ministry of Health, Social Affairs and Women's Condition. A number of annual child survival plans for 1989 were formulated. A similar meeting is planned for the end of 1989. PCU staff also participated with other donors and GOT representatives in policy and strategy sessions on specific child survival issues. However, the PCU sometimes had to invite itself to these meetings after learning of them informally. As noted earlier, donors are receptive to the idea of a PCU but share in the general confusion about the current unit's status and functions.

With respect to coordination within USAID, the project director and the chief of party have attended monthly meetings with the heads of CCCD and Family Health Initiatives in the office of the USAID project officer. As noted above, CCCD co-sponsored the December meeting with the PCU. CCCD no longer covers health education in view of the HSSCS mandate in this area. Beyond this, no intensive coordination process has been established.

Apparently because the project and SNES were not ready to launch activities under the health centers support component, involvement of the Peace Corps was postponed.

### 6.7.2 CONCLUSIONS

The PCU has made a serious effort to gain a foothold in the child survival donor community but has been hampered by problems of recognition and staff shortages described in Chapters 4 and 5. These constraints should be lifted by implementation of the recommendations in those chapters. It

will then be up to the PCU to exercise its proper role in donor coordination: helping define and bring to bear GOT priorities, rather than merely responding to donor initiatives.

The PCU's role in coordinating AID health projects has been minimal. Links between the project and the Peace Corps also need strengthening.

### 6.7.3 RECOMMENDATIONS

5. Once the PCU is on its feet, pursuant to the Chapter 4 and 5 recommendations, the USAID project officer, the project director, the chief of party, and the other USAID health chiefs, should meet and decide on specific coordination functions that will be of benefit to the USAID program as a whole and to each project.

6. Coordination with the Peace Corps should be strengthened so that volunteers can be brought into operational component activities.

## 6.8 Construction component

### 6.8.1 FINDINGS

The project agreement and the illustrative budget provide for approximately $100,000 for construction of up to two very modest child survival demonstration centers. No firm proposal for such centers has been made to date. Instead there have been discussions of alternatives such as combining AID's $100,000 with a similar amount from UNFPA to build a combined demonstration center and MCH division office complex in Lome. The latest information obtained by the evaluation team is that the UNFPA is proceeding on its own, and that its building will suffice for both demonstration center and MCH division offices. Hence options are once again open for use of the $100,000. Should it be used to build one or two demonstration centers? Alternatively, should it be applied to construction of a permanent office for the PCU, replacing the currently rented quarters? Or should the money be applied to other items in the budget?

The following factors enter into consideration. The project paper deals with the construction component as something of an afterthought, not as an integral part of the technical assistance, training and operational support interventions. The need for new demonstration centers has not been established; perhaps existing centers are adequate or can be adapted to demonstration-center use. Then the question arises of careful planning for the staffing and use of any new centers. The post-project disposition of the PCU needs to be established before the option of constructing a headquarters for it can be seriously considered. AID procedures for

approving construction are demanding and time-consuming. Finally, it is not certain whether $100,000 will be sufficient to meet the needs of any construction that may be decided upon.

### 6.8.2 CONCLUSIONS

Justifying construction under the project is difficult at this stage, for several reasons. A need for any type of structure related to project objectives has not been established. If it were, careful planning would be required not only to manage the construction but to ensure proper utilization of the building. Managing a construction component financed by AID would be very time-consuming for the small project staff and for USAID. A possibility would be to transfer the financing responsibility to the GOT project budget, with AID picking up an equivalent amount of other local costs. This might simplify the construction approval process to a degree. However, transferring $100,000 of GOT money to construction would involve nearly two years worth of GOT funding, which is being supplied at the rate of about $64,000 a year (20 million CFA). Finally, it would seem advisable to postpone any decision on construction and on implementation thereof until the project has established its viability by overcoming the structural, organizational and personnel constraints identified in this evaluation. Once that is accomplished, the need for any construction, whether financed by AID or GOT, should be weighed against other claims on the budget. All these issues can best be addressed during or after the mini-evaluation proposed for December 1989.

Additional insights on the question of construction are offered in subsequent pages by Dr. Vignon Devo, one of two Togolese members of the evaluation team.

### 6.8.3 RECOMMENDATION

7. The project staff, GOT and USAID should postpone consideration of any project-financed construction until after the mini-evaluation. Once the project's future course and budget priorities are clear, the three parties should make a firm and prompt decision on the need for and desirability of a construction component, bearing in mind the relevant planning, financing and implementation issues discussed in the evaluation.

# PROJET "SOUTIEN AU SECTEUR DE LA SANTE POUR LA SURVIE DE L'ENFANT" (USAID No.693-0228)

## EVALUATION A MI-TERME: VOLET CONSTRUCTION

A la demande du Gouvernement Togolais (GOT) il a été entrevu la construction d'un local devant abriter la direction des services destinés aux mères et aux enfants.

Cette requête introduite auprès de l'USAID et du FNUAP (Fonds des Nations Unies pour les Activités en Matière de Population) a fait envisager dans le cadre du projet, objet de la présente évaluation, la mise éventuelle à disposition d'une somme de cent mille dollars US.

### 1. Genèse de la requête et analyse du contexte de démarrage du projet Survie de l'Enfant

La Division de la Mère et de l'Enfant (DME) à la Direction Générale de la Santé Publique (DGSP) avait mission de concevoir et de coordonner toutes les activités opérationnelles à caractère sanitaire en faveur des mères et des enfants.

Dans sa mission la DME est aidée par d'autres Divisions relevant des 3 Directions Générales du Département mais il ne semble pas exister de réelle coordination ni entre les divisions ni entre les agences de coopération ou les Organisations Non-Gouvernementales.

Par ailleurs le local abritant actuellement la DME est un local baillé, exigu, peu fonctionnel et excenté par rapport aux autres structures d'intervention.

A l'origine de la requête du gouvernement se trouverait donc le souci d'avoir dans un même immeuble les organes de planification et de coordination: est recherchée l'unicité dans la conception et le suivi des actions en direction des mères et des enfants.

Cette perception n'épouse pas totalement le but du projet dans son volet Planification-Coordination puisque ce but est de fournir au Ministère de la Santé une «capacité de planification, budgétisation et coordination quant au domaine de la survie de l'enfant». Mention donc n'était pas explicitement faite de l'abri physique de cette capacité.

A la fin du projet cette capacité devra faire partie intégrante du processus gestionnaire du Ministère.

Pour une mise en oeuvre correcte du projet l'USAID paie un loyer mensuel de 300.000 FCFA, le temps du projet.

## 2. Des solutions alternatives

En considérant la situation actuelle caractérisée par:

a) l'exiguité du local abritant la Division de la Mère et de l'Enfant;

b) la location d'un autre bâtiment abritant le projet Survie de l'Enfant;

c) la probabilité d'un financement extérieur pour la construction d'un local dont l'affectation est à bien définir;

d) l'impossibilité financière actuelle du GOT d'offrir un abri adéquat à un programme de Survie de l'Enfant conduit par le Ministère de la Santé Publique, des Affaires Sociales et de la Condition Féminine, on est est amené à envisager certaines solutions alternatives.

### 2.1. La construction de la Direction de la DME sur le BIE togolais

Les procédures complexes et longues en usage à l'USAID ne permettent pas d'envisager raisonnablement une construction au cours du projet "Survie de l'Enfant" avec l'inscription des cent mille dollars US sur les lignes budgétaires de ce projet.

Un des signes de l'engagement du GOT est l'octroi au projet d'un crédit de 20 millions de Francs CFA.

Alors pour autant que les règlements techniques et administratifs du BIE (Budget d'Investissement et d'Equipement) du Togo le permettent, un transfert d'un chapitre à sur un autre pourra s'opérer jusqu'à hauteur de ces 20 millions pendant la durée du porojet "Survie de l'Enfant".

Cette modalité pourrait avoir l'aval de l'USAID si le Ministère de tutelle du projet engage le GOT dans cette voie et l'USAID dans ce cas prendrait en charge les coûts précédemment prévus par le GOT (les 20.000.000 FCFA).

Selon toute probabilité, le BIE de 1990 sera discuté en octobre 1989. Le Ministère de la Santé Publique, des Affaires Sociales et de la Condition Féminine pourra dès lors engager des négociations avec le Ministère du Plan et des Mines. Le principe d'un tel transfert étant acquis, il faudra rendre rapidemnt disponible le dossier technique <<Construction>> afin

que les travaux puissent démarrer dans les meilleurs délais.

2.2. La priorité au siège des activités opérationnelles

Une deuxième alternative peut naître de la promesse d'un financement FNUAP et d'un éventuel financement USAID, l'un pour la construction d'un centre de démonstration en SMI/RF à Lomé (FNUAP) et l'autre (USAID) pour une construction semblable dans une ville de l'intérieur du pays.

Tout projet de construction, aux yeux de l'USAID est jugé à priori basse priorité; et dans le cadre du projet "Survie de l'Enfant", le processus de planification-coordination ayant comme finalité l'intégration au processus gestionnaire du Ministère il apparait alors difficile d'envisager une construction.

3. Recommandations

Une équipe d'évaluation recommande:

1) Au Gouvernement:

Que soient explorées à la demande du Ministère de la Santé Publique, des Affaires Sociales et de la Condition Féminine les possibilités d'inscription d'un chapitre construction (un terrain étant disponible) dans les rubriques du Budget d'Investissement et d'Equipement (BIE) du Togo dès l'exercice 1990 et pour un montant équivalent à l'engagement financier actuel du gouvernement (GOT) dans le projet "Survie de l'Enfant".

2) A l'USAID:

De proposer au GOT, en tenant compte des procédures en usage au sein de l'AID, la prise en charge des coûts des dépenses actuelles qui s'élèvent à 20 millions Francs CFA.

Cette proposition est négociée dans un esprit d'incitation à mieux asseoir le projet de Soutien au Secteur de la Santé pour la Survie de l'Enfant, en particulier le volet Unité de Planification et de Coordination pour la Survie de l'Enfant.

3) Au projet "Survie de l'Enfant"

De rechercher les moyens de s'assurer une intégration effective aux structures du Ministère.

# 7.0 ADMINISTRATIVE ISSUES

## 7.1 Overall project management by the grantee, AID and the contractors

### 7.1.1 FINDINGS

Following are some impressions -- not an exhaustive review -- of project management by the three parties. They supplement relevant comments made in Chapters 4 and 5.

**Start-up delays**

There was initial delay in providing technical assistance, owing to a delay in issuing the PIO/T, lengthy contracting procedures in Washington, and difficulties in finding suitable candidates. The contract was signed in September 1988, six months later than projected in the implementation schedule. The two technicians arrived in October and December 1988, respectively, rather than in May as projected. The Togolese contingent came on board in November 1987 and initiated the organization of the project.

**Local project administration by the grantee and the technical assistance team**

The director, assisted by the accountants who were transferred from the prior RWSS project, assumed responsibility at project outset for administering both the GOT and AID local cost budgets. With the arrival of the TA team, administration of the AID local cost budget passed to the latter, and new patterns had to be established which took time to work out.

Several problems came to the attention of the evaluators that indicate some continuing difficulties. One is control over telephone usage. Prior to the arrival of the technical assistance team's chief of party (COP), the director had a private line and a long-distance, direct-dialing system installed for which detailed, call-by-call billings are not available from the telephone company. During the evaluation team's visit, the COP received a lump-sum bill for the early part of 1989 which included surprisingly high amounts for overseas calls. Their relationship to the project was not clear. The issue remains to be worked out between the director and the chief of party. The bill is payable from the AID budget. Another anomaly is that one of the drivers and a secretary on the AID payroll are assigned to the Mother-Child Health Division of the Ministry of Health, of which the project director is also the head.

Until now the COP has not been privy to the details of the host country side of the budget, whereas she has been sharing knowledge of the AID-funded local-cost budget with the director. The evaluation team stressed to the two parties and the chief accountant the importance of joint budgeting of both

accounts, and obtained a copy of the GOT project budget. It showed a 20 million CFA contribution (about $64,000) made in March 1988 and an identical contribution in 1989, an impressive showing of the GOT's financial commitment to the project. The 1988 funds were obligated before the COP's arrival; 1989 funds remain to be obligated except for five months of salaries totaling 2.7 million CFA. Purchases in 1988 included equipment and supplies for the office, refrigerators for field units which have not yet been established, and substantial amounts of gasoline coupons which apparently remain available for use. The AID budget, among other items, also includes office supplies and equipment, local salaries (for different employees from the above), and gasoline.

During a field trip to Atakpame, one of the regional operations centers, the team had a brief opportunity to speak with the local project accountant and motorcycle maintenance supervisor who report to a local medical officer. They appeared to have a good system of cross checks to control the use of gasoline and motorcycle spare parts financed from the AID local currency account. They complained that many of the motorcycles, inherited from the RWSS project, were wearing out and needed replacement.

The evaluators found the local staff with whom they came in contact to be knowledgeable and cooperative. However, staff morale received a blow when the director became ill during the team's visit and neither signed their paychecks nor delegated authority to do so. (He eventually signed the pay checks but left other bills in abeyance.) Also during the visit, the chief of party, in the director's absence, suspended one employee for cause. High officials of the ministry summoned the COP and informed her that any suspension or firing of a local employee had to be done through GOT authorities, even if the employee was paid from a donor or other external account. The COP explained her reasons for the suspension and her responsibility to USAID and the contract firm for administration of AID funds; she suggested the ministry contact USAID. As of this writing, the employee remains in suspension.

The COP also advised the evaluators that she was in the process of ending the private use of a project vehicle.

The contract team and the PSC agents' assistant have job descriptions in their contracts with USAID. No job descriptions exist for the Togolese counterparts. In his interview with the evaluators, the Director General of Public Health voiced considerable concern over the lack of job descriptions.

The evaluators found the headquarters office to be sufficiently spacious for the present staff, with good furniture and equipment and adequate office supplies. Vehicle support is good.

The contract team and the PSC agents' assistant have an excellent command of French, thus avoiding any language problem in relations with their Togolese counterparts and the support staff.

**Contractor Administration**

The TA contractor's home office appears to be giving close administrative support to the field team. There is frequent contact by correspondence and telephone. Both the contract firm, Development Assistance Corporation, and the sub-contractor, Medical Care Development, have provided specialized consultancies from their own staffs to the project. The vice president of DAC was in Lome at the time of the evaluation and provided the team with frank and knowledgeable assessments of the situation. However, it was not clear to what extent the home office was assisting in continuing technical review of project outputs per the team's scope of work (see conclusions and recommendations below).

**USAID Administration**

The USAID health project officer holds monthly meetings with his TA team chiefs, including the HSSCS chief of party. Other contacts between the project officer and the chief of party are largely by telephone and exchanges of memoranda. Section 5.1 of this paper notes several cases of inaction on key project initiatives owing to lengthy reviews within USAID or lack of clear communication between the project officer and the chief of party.

As noted in Chapter 5, the issue of salary supplements has long been up in the air. These were requested by the Togolese counterparts in early 1988 and have been under consideration between USAID and AID/W ever since.

### 7.1.2 CONCLUSIONS

**Project start-up.** Project management suffered because of the delay in the arrival of the TA team. Even if the team had arrived as planned, this would have been about five months after project start-up by the Togolese contingent. It might have been wiser, for both programmatic and administrative reasons, to await the arrival of the TA team before fully launching the project. The one element which it might not have been prudent to postpone would have been the community outreach component which inherited a well-trained staff and equipment from a just-completed water supply project. However, special efforts, perhaps through short-term TA, would have had to be made to inculcate that staff in the health emphases of the new project. As it turned out, no effective effort of this nature was made until the TA team arrived, and the conceptual transition is only now being completed.

**Headquarters conditions.** From a physical standpoint -- space, equipment, furniture, vehicles -- the project office appears to be in good shape. It is unfortunate that the headquarters is separate from the main offices of the ministry where space is very limited. However, such separation is a common condition affecting other key offices of the ministry; hence it is not a handicap unique to this project and should not unduly hinder ultimate integration of the planning function into the ministry's structure.

Other favorable aspects noted by the evaluators are the competence and experience of most of the support staff, the TA team's excellent command of French, and the apparent control exercised over spare parts and gasoline use in the field center visited.

**Management problems.** A number of problems persist. There is insufficient coordination in preparation of the AID and GOT local-cost budgets; control over operating costs and local personnel assignments needs to be strengthened; and delegations of authority from the director are essential to allow urgent decisions to be made and bills to be paid in his absence. The pressing need for a full-time director has already been discussed in Chapters 4 and 5. Job descriptions should be established for all positions lacking them.

**Salary and civil service issues.** Although the project agreement calls for the project director and the teams' assistant (not yet hired) to be paid with AID funds, the evaluation team believes USAID acted properly in not carrying out this provision. For one thing, the director has not been assigned full-time to the project. For another, to create a distinction between AID-financed and GOT-financed senior counterparts, with likely differences in pay scales, could only add to the morale problem and would operate against the long-term objective of integrating the planners into the ministry's structure upon completion of the project. A Togolese civil servant who receives his salary from project funds is detached from his civil service post and may have problems of re-entry upon project termination. This problem does not apply to personnel assigned to a project who continue to receive GOT salaries. However, as noted in Chapter 5, the issue of supplements to these salaries needs urgent resolution. If a decision is made to grant them, consideration will have to be given to extending them to the additional professional Togolese personnel proposed by the evaluation team for assignment to the project.

**Contractor and USAID support.** Contractor home office support appears to be strong administratively. It would be highly desirable -- especially during the next six months, while the project copes with a daunting array of non-technical problems described in this evaluation -- if the home office could augment its support by assisting the team in ensuring the technical completeness, timeliness and documentation of project

contributions (for guidance see in particular Sections 6.3 through 6.6). This suggestion does not stem from concern over the competence of the team, but rather from the evaluators' desire to see all available technical resources placed at the disposal of the project during this critical period.

Communication between USAID and the project team needs to be strengthened: USAID needs to take actions in more timely fashion, and the COP needs to follow up more forcefully.

### 7.1.3 RECOMMENDATIONS

1. The project director and the chief of party should establish strengthened and clearly enunciated procedures for (a) delegating authority from the director, (b) coordinating preparation of both the AID- and GOT-financed local cost budgets, (c) limiting access to project facilities such as telephones and vehicles so as to hold down costs to essential levels, and (d) ensuring that all local employees financed by the project work directly for the project. The COP should take whatever actions fall within her jurisdiction over AID funds to help achieve these objectives.

2. Once the project team is fully in place and a new work plan has been established per the recommendations in Chapters 4 and 5, the project director and the COP should prepare job descriptions for all personnel lacking them. Existing job descriptions, such as those in the AID contracts, should be updated.

3. The USAID project officer, in close coordination with the chief of party, should make a concerted effort to resolve long-standing program and administrative issues awaiting AID action.

4. The USAID and project offices should establish a pattern of more frequent and informal communication.

5. Through review of reports and documents sent in by the team and through reviews during field visits, the contractor's home office should assist the field team in ensuring the technical completeness, timeliness and documentation of project contributions, taking the contents of this evaluation (particularly Sections 6.3 through 6.6) into account. This recommendation applies particularly to the current period when the project is coping with a series of time-consuming organizational and administrative problems.

**7.2 Determine whether the contract scope of work, technical assistance and level of resources available are appropriate to meeting project objectives, and particularly that all necessary procurement and other local cost items are appropriately specified.**

### 7.2.1 FINDINGS

**Scopes of work**

The scope of work contained in the contract is consistent with the intent of the project paper and the project agreement. The technical assistance being provided under the contract also is appropriate to the project design. However, as explained in Chapters 4 and 5, serious structural and organizational problems have hindered timely execution of the planned outputs. Hence the full potential and appropriateness of the TA team in its present configuration have not been put to a definitive test.

Contract funding

Funds obligated to the contract, which was negotiated in Washington, total $2,596,000; the contract states that this amount is sufficient to cover contract performance through September 1990. An additional $902,300 is identified as necessary to complete the scope of work. This is about $300,000 more than the amount projected in the PIO/T.

The vice president of DAC noted to the evaluation team that "other direct costs" under the contract will need to be reviewed at about the 18-month anniversary of the contract in March 1990; costs have risen because of the unanticipated arrival of dependents of the contract team members. He said the PCU local-cost budget should also be reviewed at that time.

The contract has a lump-sum line item for PCU expenses. Local cost items are not defined. No specific provision is made for purchase of commodities, although USAID had expected this to be in the contract. However, Section C.5 of the contract does provide that the PCU and the contractor prepare annual local cost budgets and obtain USAID approval. To date USAID and the contractor have interpreted the line item to cover various expenditures pursuant to the overall budget in the project agreement, including computers, consumables and other operating costs for the project office, and motorcycle spare parts and gasoline for field use. (Motorcycle repair operations are specifically mentioned in paragraph C.5.f.(6) of the contract, implying that the PCU line item refers to local expenses for all components of the project.) Additional equipment for field use is to be purchased upon completion of needs assessments, but whether this will be done under the contract or through USAID remains to be worked out.

### 7.2.2 CONCLUSIONS

With respect to the appropriateness of the technical assistance provided, no changes should be considered at this time. The evaluation in Chapter 5 recommends an intensive four-month restructuring effort to get the project back on track. A

mini-evaluation in December 1989 should review the progress of this effort; as part of its task, that evaluation should review any changes that might be needed in scopes of work.

In light of partial funding to date, contract costs will need to be reviewed in the context of the overall project budget, and a PIO/T issued accordingly. The review should begin with the mini-evaluation.

In the meantime, clarification is needed as to the full scope of purchases allowable under the contract.

### 7.2.3 RECOMMENDATION

6. Before any further durables such as computers are purchased under the contract, USAID and the contractor, with REDSO/WCA assistance, should review the budget and the contract, clarify what is allowable, and arrange for any necessary changes.

# 8.0 COMPLIANCE WITH CONDITIONS PRECEDENT (CPs)

## 8.1 FINDINGS

### 8.1.1 Conditions precedent in Section 4.1 of the project agreement

**Sub-sections (a), (c) and (d).** Documentary evidence required under Section 4.1 -- conditions precedent to first disbursement of AID funds -- was cited in project implementation letter (PIL) No. 3 of January/February 1988 (no exact date is available). It noted compliance with the CP in Sub-section (a) requiring the name and specimen signatures of the GOT's official representative to the project (the Minister of PHSAWC). The PIL further noted compliance with the CPs in Sub-sections (c) and (d) concerning transfer to the project of accounting personnel and procedures from the previous RWSS project. The evaluation team concurs that these CPs have been met.

**Sub-section (b).** This CP called for documentary evidence that the Child Survival Planning and Coordination Unit had been established and would exist at least through the life of the Project. The Minister of PHSAWC signed a decree establishing the PCU, thus complying with the letter of the CP. The PIL elaborated upon the decree by specifying that the unit would operate under the minister's authority. However, the statement in the PIL was never confirmed by a clarifying GOT decree, leaving the PCU suspended without a fixed location in the hierarchy. The upshot was that the director found himself without a defined superior for his duties at PCU, while reporting to the Director General of Public Health for his duties in the Maternal and Child Health division (see below). Hence the PCU and its director were left in a highly tenuous position. It is important to note that the amplified project description in the official, English version of the project agreement called for the unit to be close to the minister. Unfortunately, for unknown reasons, this point was left out of the French translation.

**Sub-section (c).** With USAID acquiescence, this CP was not met as intended. The CP called for the grantee to assign "for full-time, life-of-project service to the Child Survival Planning and Coordination Unit, a National Child Survival Unit Director, with extensive training and experience in planning and management, who is acceptable to A.I.D. . . ." The person selected by the ministry was a chief pediatrician in an up-country hospital who had not previously been a planner or managed a central government operation. Two months before being assigned project director he had also been assigned director of the Maternal and Child Health (MCH) division of the ministry. This in turn led to his being named director of the AID and UNFPA family planning projects which fell within his

portfolio. The intention of the HSSCS project designers had been to have an experienced planner from the Ministry of Plan assigned as project director. However, the MPHSAWC felt strongly that only a medical doctor would carry weight as project director. The ministry apparently also felt that it was appropriate to place the MCH division in the same hands as a unit providing planning and operational support to child survival; this is certainly the view of the director himself, as expressed to the evaluation team. The USAID acquiesced in these decisions through PIL No. 3 by way of a formula providing that the person designated as PCU director would be assigned full-time to that position, and would provide only policy direction to the MCH division. To make this possible, the director was to obtain two UNFPA-financed assistants and an expatriate advisor within six months to manage implementation of the MCH program. In the event, however, it took more than a year to recruit the expatriate advisor, and the two service chief posts remain vacant. Thus the HSSCS project has been left with a director who has little time to devote to the project and lacks broad managerial and planning experience.

### 8.1.2 CPs in Section 4.2 of the project agreement

**Sub-section 4.2 (a).** This CP sates that "except as A.I.D. may otherwise agree in writing, prior to any disbursement or the issuance of any commitment documents under this Agreement beyond the twenty-fourth project month (i.e., August 8-September 7, 1989), an in-depth evaluation during the twenty-first Project month specifically must have concluded that there had been evidence of sufficient GOT commitment to the project during the first twenty-one months to warrant a recommendation for project continuation." The evaluation occurred during the twenty-third and twenty-fourth months of the project.

The CP continues by specifying the set of items that would constitute the minimum evidence of GOT commitment. These are listed below with the evaluation team's summary comments on the level of fulfillment. The comments draw upon more detailed information in other parts of this evaluation.

- Satisfactory application of effective procedures developed for implementing the project.

  Procedures within the outreach component are satisfactory; within the health centers component, they are just being developed; within the headquarters office, they are partially unsatisfactory (see Section 7.1.1 above); between the PCU and the rest of the ministry, they have not been made systematic; between the PCU and other donors, they remain to be clarified.

- Satisfactory perfor ce of the Unit Director.

  In light of his sporadic and limited presence, lack of broad manager' and planning experience, and problems of administration, the team finds performance unsatisfactory.

- Satisfactory performance of each senior MOH official seconded to the Unit for service as Unit Coordinator.

  Performance of the community outreach coordinator, assigned from the Directorate General of Social Affairs, has been satisfactory. Performance of the coordinator from the Ministry of Plan, who until now has been designated to head the health centers support component, has been virtually nil, owing to his near-total absence from the project.

- Full operation and satisfactory effectiveness of the Unit and the Advisory Board.

  For the external and internal reasons cited in the evaluation, the PCU -- and the project as a whole -- operate under severe constraints and with unsatisfactory effectiveness. The Advisory Board has never met and has no chairman designated.

- Satisfactory quality, quantity and promptness of cooperation forthcoming from MOH entities (including, but not limited to, the National Health Education Service (SNES), the Division of Epidemiology, the Division of Maternal and Child Health, and participating agencies of the Directorate of Social Affairs), which have expertise and resources needed for project implementation.

  SNES, which is most concerned with the health centers support component, was initially reserved about working with the IEC advisor, and has been slow to accept the project's operational objectives; it now appears more amenable to cooperation. The evaluators were not made aware of any other reluctance to cooperate. The Division of Maternal and Child Health is headed by the same person as the HSSCS project. The Directorate of Social Affairs has good relations with the community outreach coordinator. The Division of Epidemiology, which directs the CCCD project, seems ready to cooperate. However, the project so far has made few demands on the different services, making it difficult to judge quality, quantiy and promptness of cooperation. The directors general and the director of Epidemiology all indicated they had no clear sense of where the project, especially the planning/coordination component, was heading.

- Satisfactory, appropriate facilities obtained by the Grantee for the Child Survival Planning and Coordination Unit.

The facilities obtained are satisfactory and appropriate.

- A detailed Grantee Plan, in which A.I.D. has concurred, for the Grantee's assuming the costs of petrol, oil, lubricants, and repairs for the motorcycles used by Teams and Community Agents so that these groups retain their full mobility after the project ends.

The Grantee has not yet prepared a detailed plan for assuming the above costs after the project ends. (NB. The project paper on page 38 estimates the post-project costs for operating motorcycles at $140,000 a year; additional recurrent costs for new motorcycles, vehicle operations, personnel, IEC materials and per diem/ transportation are estimated at $150,000 a year.)

**Sub-section 4.2(b).** This CP concerns adequacy of building plans, material and cost estimates, and other documents related to construction financed under the grant. As no firm plans have been made for construction to date, the CP remains for possible future application.

## 8.2 CONCLUSIONS

**CPs in Section 4.1.** Three CPs have been fully met. The CP calling for the establishment of the PCU has been met only in a narrow sense. Functionally, the PCU is in a highly tenuous position. Chapters 4 and 5 provide the rationale and recommendations to resolve the situation

In PIL No. 3, USAID agreed that the ministry had met the CP concerning assignment of a director. However, USAID did so by accepting a director with limited experience who also held other major responsibilities. USAID sought through the PIL to have the director assigned full-time to the PCU by having his other position as head of MCH limited to policy direction. This did not work out, and probably was doomed to failure even if the three assistants had been recruited promptly. USAID compounded the problem by accepting the same person as director of both its child survival and family planning projects -- the latter by virtue of his being director of MCH which is charged with family planning. The recommendations in Chapters 4 and 5 address this problem by calling for a full-time director who is equal to the challenging tasks of the position.

**CPs in Section 4.2.** Two CPs in this section have been met: the mid-term evaluation has been held (albeit two months late), and the project facilities are satisfactory and appropriate. However, the evidence of sufficient GOT commitment to warrant a recommendation for project continuation is sparse.

Based on this evidence, the evaluation team could conclude that the project is not producing results of lasting value for development, and could recommend that USAID terminate its commitment to the project. The team does draw the conclusion,

but recommends giving the project a second chance. In Chapter 5 the team recommends that the project be given until November 30, 1989 to meet a set of benchmarks that would make the project minimally functional and able to produce sustainable results. The reasons for this approach are twofold:

- GOT has demonstrated clear commitment to the project in the form of timely financial contributions, and

- the GOT officials, USAID personnel and project team members who were interviewed by the team all expressed great interest in the project, yet frustration at the difficulties it was encountering; they were looking to the evaluation team to recommend solutions.

The team has endeavored to lay out a feasible course of action, specifying the role that each of the three parties must play to set this long-stalled project on a productive course within a short period of time. If they succeed, the mini-evaluation proposed for December 1989 will be justified in recommending continuation. If they fail, termination of the project, or deficient portions thereof, would appear to be the appropriate solution.

## 9.0 LESSONS LEARNED

**9.1 Need for high-level support.** This project seeks to alter a process of vertical, program-by-program planning by adding a horizontal dimension of coordinated planning and budgeting across the spectrum of child survival activities. Such a project involves major modifications in long-standing institutional patterns; it cannot succeed without strong policy support from high levels of government, especially from the ministry most directly engaged in the project. It is essential that designers of such projects try to make certain in advance that the needed support will indeed be forthcoming. The HSSCS project paper does not show evidence of questioning by the designers in this regard; the necessary support was simply assumed.

**9.2 Late arrival of technicians.** The implementation schedule in the project agreement provided for immediate start-up of implementation by the host country counterparts, with the arrival of the expatriate advisors scheduled for month 9. In fact, the two advisors arrived in months 13 and 15, respectively. In either case, given the challenge of institutional change posed by the project, it would have been preferable to limit initial activities to logistic matters pending the advisors' arrival. This would have allowed for a smoother start both administratively and programmatically. The one exception might have been to allow the prompt incorporation of the staff and equipment of the former Rural Water Supply and Sanitation project into the new project, so as not to lose them to other activities. A prompt transfer was in fact made -- but with the difficulties described below.

**9.3 Merging of project staffs.** The incorporation of the water supply project staff into HSSCS before the new project was effectively launched programmatically resulted in that staff proceeding initially with old project objectives. This problem might have been avoided or mitigated through a special effort by USAID or short-term advisors, pending the arrival of the long-term advisory team, to inculcate the staff in the new health objectives and show how they built upon the successes of the prior project. The lesson, then, is to ensure prompt reorientation of staff in a situation of this kind.

# ANNEX 1

## Outputs from PP

| NARRATIVE SUMMARY | OBJECTIVELY VERIFIABLE INDICATORS |
|---|---|
| Outputs: | |
| Planning and Coordination Component: | Magnitude of Outputs |
| -- Ten year National Child Survival Policy and Strategy Paper | — One |
| —Annually executed process of five-year Child Survival Plan and Budget | — One process implemented at least twice |
| -- Inventory of ongoing and proposed Child Survival activities in Togo | — One |
| -- Eight year Child Survival Training Plan and Budget | -- One |
| — Study of recurrent costs and sustainability of Child Survival activities | — One |
| — Child Survival Planning and Coordination Unit | — One |
| -- Child Survival Advisory Board | — One |
| — Commission for Child Survival | — One |
| -- MOH personnel trained in planning and budgeting techniques, and their applicability to Child Survival program implementation: | |
| *Directors General, Division Chiefs, other senior central-level officials | — about 20 |
| *senior operational central-level staff | — about 20 |
| *Regional officials | — about 15 |
| *Chief Prefecture doctors (21) plus one assistant, and up to 8 other key prefecture-level staff | — about 50 |
| -- Training curricula, field-tested instructional aides, training manuals, plan and budget preparation directions, standardized budget formats, and uniform costing indices for planning and budgeting training | — one core set with variants as appropriate |

| NARRATIVE SUMMARY | OBJECTIVELY VERIFIABLE INDICATORS |
|---|---|
| — Collaborative Technical Protocols with agencies (such as CCCD, UNICEF, FHI-II, PVOs) and MOH entities (Division of Epidemiology and Maternal and Child Health, National Health Education Service, Sanitation Service, Plateaux and Savanne regional Social Affairs and Sanitation organizations) with which coordination is essential for technically sound delivery of Child Survival services, and for a fully operation national Child Survival effort. | — up to 50 over LOP to specify cooperative arrangements and assign responsibilities of participants for activities funded or facilitated by this project. |
| -- Inclusion of Child Survival subjects in curricula of institutions training medical personnel. | — 5-8 institutions |

| NARRATIVE SUMMARY | OBJECTIVELY VERIFIABLE INDICATORS |
|---|---|
| Outputs: | |
| Health Centers Support Component: | Magnitude of Outputs: |
| -- Mobility of SNES Prefecture Health Education Teams (Teams) | -- 21 Teams, 42 individuals |
| -- Trained, experienced Teams in:<br>1) effective interpersonal approaches;<br>2) general adult health education techniques; and,<br>3) coordinated planning and implementation of health activities. | -- 21 Teams, 42 individuals |
| -- Trained, experienced Teams in:<br>1) the substantive rudiments, underlying rationales, and efficacy of key Child Survival measures (vaccination, ORT, malaria treatment, nutritional surveillance/growth monitoring, and voluntary-family planning);<br>2) demonstrating and applying home-administered Child Survival measures (ORT, presumptive malaria treatment, Guinea worm prevention), and,<br>3) the effective publicizing, promotion and demonstration of -- and adult health education techniques for -- Child Survival measures.<br>This training will be pursuant to Collaborative Protocols. | -- 21 Teams, 42 individuals |
| -- Monitoring and supervision of Teams by Teams' Assistant. | |

| NARRATIVE SUMMARY | OBJECTIVELY VERIFIABLE INDICATORS |
|---|---|
| -- Team-instructed Health Center-based Public Health staff in same subjects (except for activity planning) as Teams' training. | — 1,300 Public Health personnel |
| -- Uniform, correlated instructional curricula, manuals, audio-visual aids, demonstration packets, and reference materials for Teams' training sessions by IEC Specialist and cooperating instructors, and for Teams' subsequent use in working with Public Health staff. | — One set |
| -- Consistent, correlated IEC materials on Child Survival topics for distribution to villagers. | — One set |
| -- Teams' quarterly reports on their instruction and follow-up of Health Center staff, and other project-financed activities. | — 4 per year per in-place Team |
| — Teams' Assistant's quarterly reports | — 12 |
| — Child Survival Demonstration Centers | — 2 |

| NARRATIVE SUMMARY | OBJECTIVELY VERIFIABLE INDICATORS |
|---|---|
| **Outputs:** | |
| **Outreach Network Component:** | |
| -- Mobility of Community Agents (about 72 Social Affairs and about 48 Sanitation field workers) in Plateaux and Savanne. | -- 120 Agents |
| -- Upgraded community mobilization skills of Community Agents from refresher courses in this subject. | -- 120 Agents |
| -- Trained, experienced Community Agents in: 1) the substantive rudiments, underlying rationale, and efficacy of key Child Survival measures (vaccination, ORT, malaria treatment, nutritional surveillance/ growth monitoring, and voluntary family planning); 2) the application of home-administered measures (ORT, presumptive malaria treatment, Guinea worm prevention); 3) the circumstances indicating Health Center treatment is necessary; and, 4) the effective publicizing, promotion, and demonstration of -- and adult health education techniques for -- Child Survival measures, with emphasis on EPI, ORT, and malaria. This training will be pursuant to Collaborative Protocols. | -- 120 Agents |
| -- Monitoring and supervision of Community Agents by Agents' Assistant. | |
| -- Community Agent-conducted Field Days on Child Survival topics for groups of village leaders and VDC designees. | -- at least 480 during project |

| NARRATIVE SUMMARY | OBJECTIVELY VERIFIABLE INDICATORS |
|---|---|
| — Uniform, correlated instructional curricula, manuals, audio visual aids, demonstration packets, and reference materials for Community Agents' training sessions by Agents' Assistant, IEC Specialist and cooperating instructors, and for Agents' subsequent use in working with and for distribution to village clients. | — One set |
| — Agents' quarterly reports on their project-financed activities. | — at least 15 per Agent |
| — Agents' Assistant's quarterly reports. | — at least 12 |
| <u>All Components</u> | |
| — upgraded SNES graphics | — TV, poster, pamphlets, and other materials |
| — SNES Child Survival mass media campaigns which support Teams' and Agents' promotion of Child Survival measures. | |
| — IEC activities | — 5-10 campaigns |
| — KAP surveys | — multiple as needed |
| — recurrent cost/sustainability study | — up to 3 |
| — Collaborative Protocols with GOT entities, donors, and PVOs | — One |
| — Evaluations | — 2 |
| — Audits | — One |

ANNEX 2

Excerpts from 10/88 - 03/89 PIRS

C. PROJECT OUTPUTS:

| Outputs | Indicators/ Targets | Cum. Thru Previous Period | Present Period | Total Cumulative | Percentage Achieved |
|---|---|---|---|---|---|
| I. PLANNING/COORDINATION UNIT: | | | | | |
| CS Planning/Coordination Unit established | 1 | 1 | 0 | 1 | 100 |
| Meetings of National CS Advisory Board | 12 | 0 | 1 | 1 | 8 |
| Meetings of National CS Commission | 12 | 0 | 1 | 0 | 8 |
| 10-Year National CS Policy and Strategy Paper | 1 | 0 | 10% | 0 | 10 |
| 8-Year National Training Plan and Budget | 1 | 0 | 0 | 0 | 0 |
| National Inventory of Actual and Proposed CS Activities | 1 | 0 | 0 | 0 | 0 |
| Annually Executed Process of Five-Year CS Plan and Budget | 1 | 0 | 0 | 0 | 0 |
| Key MOH Personnel Trained in Planning/Budget Techniques | 100 | 0 | 0 | 0 | 0 |

| Outputs | Indicators/ Targets | Cum. Thru Previous Period | Present Period | Total Cumulative | Percentage |
|---|---|---|---|---|---|
| Collaborative Agreements with Donors Involved in CS Activities | 50 | 0 | 3 | 3 | 6 |
| US Masters-level training in Public Health Administration and Planning | 2 | 0 | 0 | 0 | 0 |
| Construction of Child Survival Demonstration Centers | 1 | 0 | 0 | 0 | 0 |
| II. HEALTH CENTERS SUPPORT COMPONENT: | | | | | |
| Mobility of Prefecture Health Ed. Teams (provision of motorcycle, to SNES Agents) | 60 mobile agents | 0 | 0 | 0 | 0 |
| Training of Health Ed. Teams in Technical and Socio-Cultural Aspects of CS Activities | 21 teams | 0 | 30 Agents /1 wk. | 30 Agents /1 wk. | N/A |
| Health Ed. Teams Upgrade CS and Health Ed. Skills of MOH MOH personnel Based in Fixed Centers | 21 teams 350 centers 1300 MOH personnel | 0 | 0 | 0 | |

| Outputs | Indicators/ Targets | Cum. Thru Previous Period | Present Period | Total Cumu-lative | Percentage Achieved |
|---|---|---|---|---|---|
| Elaboration of Uniform, Cor-related Instructional CS Health Ed. Curricula for both MOH Fixed Centers personnel and village use | 6 sets | 0 | 1/2 set | 1/2 set | 8 |
| III. COMMUNITY OUTREACH COMPONENT: | | | | | |
| Mobility of Outreach Agents (provision of motorcycles, spare parts, fuel, etc.) | 120 | 120 agents w/ motorcycles | 0 | 120 | 100 (ongoing) |
| Community Mobilization Training for Outreach Agents | 1,440 days (4 days/ (yr/120 agents) | 2 days/40 Agents Total = 80 days | 0 | 80 days | 6 |
| Health Ed. and CS Technical Training for Outreach Agents | 2,880 days (8 days/ (yr/120 agents) | 0 | 0 | 0 | 0 |
| CS Activities (i.e. CS Field Days (for Villages in Two Regions of Agent Outreach Program | 9,600 days (4 days/ (yr/800 villages) | 0 | 0 | 0 | 0 |

B. Progress Towards Meeting EOPS:

Planning and Coordination Unit (PCU)

1. Long-term technical assistants, COP/Health Planner (DAC) and IEC Specialist (MCD), arrived 10/88 and 12/88, respectively, and now fully installed.

2. A model for decentralization of Information, Education and Communication (IEC) and training activities at the National Social Mobilisation Seminar was presented by project team.

3. The manual for project's local currency managerial system was drafted and is now under review.

4. PCU assisted in the execution, and financed one-third of the MOPH 1989 National Planning Exercise conducted in collaboration with other major donor agencies.

5. A computer workshop for PCU staff, and upper-level MOH personnel was held in December 1988.

6. In January a major seminar on project's objectives and strategy was conducted. Participants numbered 40 and were upper-level representatives of all three MOPH Directorates, Ministry of Plan and other donor agencies, and constituted project's first meeting of National Child Survival Advisory Board. Seminar led to major recommendations for project's implementation and possible amendment.

7. PCU planned and implemented nation-wide training of prefectoral health and social affairs personnel in prevention, control and treatment of diarrheal diseases.

8. PCU officials participated in 10-day World Bank workshop for the design of Togo health sector project. Major outputs included: initial work on 10-Year CS Training and Operational Strategy; draft of strategy and budget for national health education rural outreach; definition of national priorities and long-term (10-year) MOPH objectives.

9. Negotiations were initiated with U.S. educational institutions for design and implementation of management seminar for key MOH Child Survival personnel planned f 08/89.

10. PCU officials participated in seminars on National Malaria Policy, National Nutrition Policy, and provided assist to various missions of French cooperation, Conseil de l'Enter.

Health Centers Support Component

IEC Specialist assisted in planning, and facilitation of nation-wide diarrheal disease control training for prefectoral health and social affairs personnel (see No. 7 above). Specialist's participation included directing health education group in developing IEC materials for use in MOPH centers and village extension programs, and facilitating four (4) week-long training sessions.

Community Health Component

1. Quarterly planning meeting was conducted with participation of regional directors of Social Affairs, Hygiene, and Health Education, and national representatives of Community Developement. Meeting included planning of initial survey on organisational capacity of established Village Developement Committees (VDC), programming revision of VDC training manuals, and planning of three-day community mobilisation seminar for 120 MOH field agents.

2. PCU initiated and sponsored week-long workshop for redefinition of VDC role and revision of manual used in training of same to be used by Community Outreach, health education, and other GOT rural extension agents. Manual to be used in VDC training program initially involving over 300 villages.

ANNEX 3

## C. IMPLEMENTATION SCHEDULE

The following illustrative scenario sets preliminary targets and assigns responsibility for completion of implementation actions which will have to be met to achieve the project purpose within the envisioned life of project. Numbers in parentheses specify project months within a quarter when estimates of this level of detail might be helpful.

| PERIOD | ACTION | RESPONSIBILITY | DATE ACCOMPLISHED AND/OR COMMENTS |
|---|---|---|---|
| PRE-IMPLEMENTATION: | | | |
| | PIO/T for US-procured Technical Assistant | Mission | - |
| | PIO/T for US PSC for Agents' Assistant | Mission | - |
| | PIO/T for Togolese Teams' Assistant | Mission | - |
| | Nomination of Unit Director and of 2 MOH Unit Coordinators | GOT | - |
| FIRST QUARTER, MONTHS 1-3: 09-11/87 | | | |
| | Project Agreement Signed (1) | GOT & Mission | 09/87 |
| | Unit Organized—Unit Director & 2 MOH Unit Coordinators seconded (1) | GOT | 11/87 (Dir-MOH 2 Coordinators-MOH and Plan) |
| | Unit premises procured/equipped (1) | GOT & Mission | Procured 06/88 Equip. cont'g. |
| | Advisory Board organized, Chairman designated (1) | GOT (MOH) | -0- |
| | RWSSP Accountants & Support Staff engaged for Health Sector Child Survival Project (1) | GOT Contract | 01/88 |
| | Procurement process of long-term technical assistance services from an 8A firm initiated | AID/W | 09/87 |
| | Agents' Assistant PSC signed (2) | Mission-REDSO/WCA | 02/88 |
| | Teams' Assistant PSC signed (2) | Mission-REDSO/WCA | -0- |
| | Child Survival Commission organized, & President designated (3) Assistants | Unit/Board/ Mission/both | -0- |

| PERIOD | ACTION | RESPONSIBILITY | DATE ACCOMPLISHED AND/OR COMMENTS |
|---|---|---|---|
| SECOND QUARTER, MONTHS 4-6: 12/87-02/88 | | | |
| | RWSSP capital assets transferred (4) | GOT | 01/88 |
| | Teams' and Agents' Assistants begin services (4-39) | Both Assistants | Agents: 02/88<br>Teams': -0- |
| | Advisory Board meets twice, to continue meeting at least twice a quarter throughout this project | Board | -0- |
| | Commission meets twice to continue meeting at least twice a quarter throughout the project | Commission | -0- |
| | Agents' first refresher courses in community mobilization, to total about 15 during the project | Agents' Assistant | 06/89 |
| | Four Child Survival Field Days held to total about 45 during the project | Agents' Assistant | -0- |
| THIRD QUARTER, MONTHS 7-9: 03-05/88 | | | |
| | Long-term tech. assist. contract signed (about 7) | AID/W | 09/88 |
| | ETA Health Planner (9--to stay thru 44) | TA Contractor | 10/88 |
| | ETA IEC Specialist (9--to stay thru 44) | TA Contractor | 12/88 |
| | Teams' training in communications skills for enhanced interpersonal and community relations; to total about 15 1-day sessions per Team during the project | Teams' Assis. & IEC Specialist | -0- |
| | Teams' training in coordinated planning & implementation of health activities begins, to total about 15 1-day sessions per Team during the project | Teams' Assis. & Health Planner | -0- |
| FOURTH QUARTER, MONTHS 10-12: 06-08/88 | | | |
| | Ten Year Policy & Strategy Paper drafting begins | Unit, Senior Advisor/Planner | Begin 03/89 |

| PERIOD | ACTION | RESPONSIBILITY | DATE ACCOMPLISHED AND/OR COMMENTS |
|---|---|---|---|
| | Planning/Budget materials & standardized forms preparation | Unit, Senior Advisor/Planner | -0- |
| | Planning/Budget materials & standardized forms field testing begins | Unit, Senior Advisor/Planner | -0- |
| | Format for Collaborative Protocols drafted | Unit, Senior Advisor/Planner | 3 informal agreements concluded |
| FIFTH QUARTER, MONTHS 13-15: 09-11/88 | | | |
| | Ten Year Child Survival Policy & Strategy Paper promulgated | MOH/MOP/President | ongoing |
| | Planning/Budget Training begins with the following Indicative Scenario & suggested locations: | | |
| | Nat'l.-Level Directorate & Division Chiefs, 3 days (early 13): Lome<br>Nat'l.-level Operational Staff 3 above days plus 2 more days (early 13): Lome | Unit, Senior Advisor Planner<br>IEC Specialist,<br>Collaborative Agencies,<br>Short-term Tech. Asst. | |
| | Regional officials, 2 days (mid 13): Lome | A) Strategy redefinition and needs assessment 03/89-04/89 | |
| | Prefect-level personnel, 1st region, 4 days (late 13): regional capital<br>Prefect-level personnel, 2nd region, 4 days (week 1, 14): regional capital<br>Prefect-level personnel, 3rd region, 4 days (week 2, 14): regional capital<br>Prefect-level personnel, 4th region, 4 days (week 3, 14): regional capital<br>Prefect-level personnel, 5th region, 4 days (week 4, 14): regional capital | B) TOR drafted for training sent to USAID 05/89<br>C) Awaiting USAID concurrence/comments | |
| | Child Survival Inventory finished | Unit, PSC, Commission Collaborating Agencies/Short-term Technical Assistance | Begun 07/89, to end 08/89 |

| PERIOD | ACTION | RESPONSIBILITY | DATE ACCOMPLISHED AND/OR COMMENTS |
|---|---|---|---|
| | Participants leave for US Masters trng. | Mission, Unit, MOH - Process initiated | -0- |
| | Teams' and Agents' Child Survival trng. pursuant to Collaborative Protocols begins, to continue throughout the project on an "as available basis". | Unit, MOH entities, other organs. such as CCCD, UNICEF, Donors, PVOs, religious organizations | First Training 03/89 |
| SIXTH QUARTER, MONTHS 16-18: 12/88-02/89 | | | |
| | Directive to initiate Planning/Budget GOT exercise (early 16) | 1st annual planning exercise 12/88 GOT | process initiated |
| | Reinforcement Assistance to preparers: Up to 2, 5-day trips to each region if needed | Unit, Long-term tech. asst. | -0- |
| | Plan/Budget materials submitted to Unit (end 18) | Nat'l., Reg'l., & Prefecture MOH Personnel | -0- |
| | Child Survival 8 Year Trng. Plan finished | Unit, PSC, Collaborating Agencies, Short-term tech. asst. | process initiated |
| SEVENTH QUARTER, MONTHS 19-21: 03-05/89 | | | |
| | Analysis of planning/budget materials, forms submitted | Unit, Senior Advisor/Planner | -0- |
| | GOT negotiations for funds allotment to MOH | MOH, assisted by Unit Director and Senior Advisor/Planner | -0- |
| | Recurrent cost/sustainability study | Unit, Senior Advisor Planner Short-term tech. asst. | Planned 1st quarter 1990 |

| PERIOD | ACTION | RESPONSIBILITY | DATE ACCOMPLISHI AND/OR COMMENTS |
|---|---|---|---|
| | Mid-term evaluation (21, i.e., after completion of first planning & budgeting exercise & related recapitulation sessions) | Short-term Tech. Asst., REDSO/WCA, Unit, Mission, Long-term tech. asst., PSCs, Collaborating Agencies | 07/ |
| EIGHTH QUARTER, MONTHS 22-24: 06-08/89 | | | |
| | Announcement of funds allotment--to MOH inter-alia | GOT | |
| | Follow-up planning & budgeting recapitulation sessions--1-day ea. nat'l. reg'l. (both in Lome), & 5 Prefectures (in respective reg'l. capitals) | Unit, Long-term tech. asst. | |
| NINTH QUARTER, MONTHS 25-27: 09-11/89 | | | |
| | Solicitation of A&E Services for construction of 2 Child Survival Demo. Centers | Mission | |
| | Mid-term audit (25) | Financial Management IQC | |
| TENTH QUARTER, MONTHS 28-30: 12/89-02/90 | | | |
| | Construction completed of 2 Child Survival Demonstration Centers | Construction firm, A&E firm | |

PROJECTIONS OF SUBSEQUENT ACTIONS UNDER PLANNING AND COORDINATION COMPONENT

| ACTION | ESTIMATED TIME | RESPONSIBILITY |
|---|---|---|
| 2nd Directive to initiate Plan/Budget exercise | month 28, 10th Q 02/90 | GOT |
| Plan/Budget materials/ forms submitted to Unit | month 30, 10th Q 04/90 MOH personnel | Nat'l., Reg'l., Prefecture |
| Unit analysis, recommendation drafting | month 31, 11th Q 05/90 | Unit, Senior Advisor/Planner |
| GOT funds allocation announcement | month 33, 11th Q 07/90 | GOT |

| ACTION | ESTIMATED TIME | RESPONSIBILITY |
|---|---|---|
| Recapitulation session (1 day each nat'l., reg'l., 5 for prefectures) | 12th Q | Unit, Senior Advisor/Planner |
| 3rd Directive to initiate Plan/Budget exercise | month 40, 14th Q 02/91 | GOT |
| Plan/Budget materials/ forms submitted to Unit | month 42, 14th Q month 43, 15th Q personnel | Nat'l., Reg'l., Prefecture MOH |
| Unit analysis/recommend-ations drafting | month 43, 15th Q 05/91 | Unit, Senior Advisor/ Planner |
| GOT funds allocation announcement | month 45, 15th Q 07/91 | GOT |
| Recapitulation session (1 day each nat'l., reg'l., 5 for Prefectures) | 16th Q | Unit |
| ETD Senior Advisor/Planner | end month 44 | Long-term tech. asst. contractor |
| ETD IEC Specialist | end month 44 | Long-term tech. asst. contractor |

FINAL EVALUATION AND AUDIT SCHEDULE

| | | |
|---|---|---|
| Final evaluation i.e., preceding end of service of both Assistants | 12/91 month 38, 13th Q REDSO/WCA, Unit, Mission, Long-term tech. asst., Collaborating agencies | Short-term tech. asst. |

## ANNEX 4

## REVIEW OF TOGO'S CHILD SURVIVAL PROGRAMS AND POLICIES

In Togo, as in the rest of Africa, morbidity and mortality, mostly in children less than five years old is high. Malaria, diarrheal diseases, broncho-pulmonary diseases and malnutritional and other infectious diseases are prominent among the causes.

Although Togo's health problems have had much in common with those of other developing countries from Niger to Botswana, the country's efforts in reducing Togo's health status indicators have changed little in the past two decades. The health indicator giving the greatest cause for alarm is the infant mortality rate which is believed by health experts to have increased from 90.2 per thousand to well over 107 per thousand in rural areas. This situation exists in spite of the fact that Togo's efforts in reducing childhood diseases have included promising and innovative features not observed in child survival programs in many other African countries. A brief sketch of Togo's child survival efforts is in order.

Togo, like most developing countries is working to extend health services into previously underserved areas. Unlike many countries, Togo has been able to have many of the community agents focus on preventive services, such as water, and sanitation, rather than on the treatment of emergencies and wounds and other curative services. The community agents in Togo have been able to carry out education programs, assist in vaccination campaigns and organize environmental improvement efforts.

Senior and middle-level health officials responsible for implementing health programs in Togo understand primary health care and the need for inter-sectoral coordination and decentralization of authority. However, implementing these themes is inhibited by a highly vertical structure of related services, particularly at the central level. Horizontal, operational coordination is more advanced at the regional and prefectoral levels.

For the purpose of this paper, "infant" shall mean a person aged 0-1 year and "child" shall mean a person aged 1-5 years, and Infant Mortality Rate (IMR) shall mean infant mortality per 1,000 live births.

Since the 1970's, UNICEF, USAID, FED, West Germany, the French Aid and Cooperation Fund (FAC), Denmark (DANIDA) and Canada have provided varying levels of support and funding for activities which support child survival.

UNICEF has been a leader in supporting for vaccination campaigns, maternal and child health, health education and malaria control.

USAID has supported family health which included support for maternal and child health (MCH), family planning training, and the provision of contraceptives and other commodities for MCH centers.

West Germany has been active in supporting Togo's health sector since 1960. DANIDA, FAC, FED and the Canadians have focused their efforts mostly on potable water either for major cities or village level systems. In addition to potable water, these donors have provided modest support to other activities such as health education and the building of health facilities and health community development efforts.

In the early 1980s, UNICEF and USAID were major contributors to Togo's community-based Primary Health Care (PHC) program. UNICEF provided assistance in MCH, nutrition, malaria control and health education. USAID began the funding of the Rural Water Supply and Sanitation (RWSS) project in 1980 with the objectives of providing potable water, sanitation facilities and complementary health education and community participation in the Savanna and Plateaux regions.

By 1983, USAID began the Combating Childhood Communicable Diseases (CCCD) project. It supports vaccination (against diphtheria, whooping cough, tetanus, measles, polio and tuberculosis), control of diarrheal diseases through the use of oral rehydration therapy (ORT), and presumptive treatment of malaria. Other support is provided for training, health information system development, and health education and operations research. UNICEF supports vaccination campaigns, diarrheal control, nutrition, MCH, health education and community health development, malaria and supplementary feeding programs.

**Government of Togo (GOT) Health Policy**

GOT has adopted the PHC strategy as the foundation of its health system. The GOT's latest policy emphasizes two main strategies for improving the population's health status: primary health care, and planning and management. Also emphasized in the GOT's policy announcements are community participation and intersectional coordination. Mothers, children and those living in unserved areas have been identified as priority groups. Prevention and promotion are featured approaches being used to achieve the government's objectives, as the following prioritized ranking of health programs shows:

- the Expanded Program of Vaccination (EPI), and the Health Information System (HIS) share first priority;

- mother and child health (which in Togo includes ORT, nutritional surveillance and family health [which is understood to include child spacing]);

- health-related information, education, and communication (IEC) on mass, small group, and individual levels;

- malaria treatment, and

- rehabilitation of health facilities.

This short background of Togo's health status situation, the health policy context and donor assistance to GOT in the provision of health services indicates these trends:

-- The most recent GOT health policy and statement places an emphasis on PHC, with child survival and women's health playing a prominent role in improving the population's health status.

-- Donors have provided substantial financial support and technical assistance to the GOT over the past two decades.

-- Despite the substantial progress made in the health sector over the past 15 years, high levels of infant and child mortality persist as the most serious health problems facing Togo at present.

Health experts still believe that with properly executed child survival interventions, political commitment from the government, and more effective use of human and financial resources, most of Togo's infant and child mortality is preventable.

A recent review of health conditions in countries receiving AID assistance has shown that health conditions have improved. It is assumed that health programs have played a major role in that improvement. For 75 AID.recipient countries analyzed, average infant mortality declined from 132 deaths per 1,000 live births in 1970 to 114 in 1980 and to 98 in 1985. Life expectancy at birth in the AID recipient countries increased significantly from 48 years in 1970 to 53 years in 1980 to 56 years in 1985. "(BINNENDYK, Annette, 1986. "A.I.D.'s Experience with Health Projects." Washington, D.C.: Center for Development Information and Evaluation, A.I.D. Draft.)

The GOT, along with many donor organizations, particularly UNICEF and AID, believes that child survival is the most important means of improving health status in developing countries. It is estimated that up to one-half of all infants' and children's deaths could be prevented with immunization, presumptive treatment of malaria and the effective use of oral rehydration therapy to treat diarrhea. Nutritional assistance and child spacing enable surviving children to be healthier and stronger.

According to the Health Sector Support for Child Survival project paper, critical efforts to launch, maintain and sustain a durable child survival program require investment in:

- public health personnel training in communications skills, in the elements of a comprehensive child survival program, and their coordinated administration, and in child survival service delivery;

- instructional materials;

- medical commodities for health interventions;

- logistical capability to transport personnel and appropriate medical and educational equipment to rural health centers and to village communities;

- mobilization of communities and health center staff for a more participative, collegial approach to health care, and

- an effective system of planning, budgeting, and coordination to administer the program.

## REVIEW OF SPECIFIC CHILD SURVIVAL POLICIES

One important health goal in Togo is improved health status for children under the age of five years. This is the group that suffers excessive mortality relative to other age groups in Togo. Reducing mortality in children under five has been stated as improving child survival. The evaluation team found a stated child survival policy statement, but no operational child survival policy. From the evaluation team's review of existing programs in Togo, we interpreted the child survival package to include:

- Immunizations

- Control of diseases - ORT

- Malarial control

- Nutrition, including growth monitoring and food supplementation

- Maternal and child health/child spacing.

- Sexually Transmitted Diseases including AIDS

A brief summary of the evaluation team's findings related to child survival planning, managing and evaluating include:

### Immunization Policy

A well-designed operational policy on immunizations in general, and on measles immunization specifically has existed in Togo for several years. Togo's CCCD project provides evidence that mortality in children caused by immunizable preventable diseases is on the decline.

## Diarrheal Disease Policy

There is no detailed diarrheal policy in Togo which includes the four strategies for Control of Diarrheal Disease (CDD) recommended by WHO. Early in the year, the MPHSAWC began working on a plan of action for 1989. At the time of the evaluation team's visit, this simplified action plan and a national policy on diarrheal disease were near completion.

## Malaria Control Policy

A seminar was held earlier this year to commence work on the definition of a national malaria policy. Plans of action for 1989 include the following components:

- Operations research

- Training

- Evaluation

- National Policy on Alimentation/Nutrition

## Maternal and Child Health/Family Planning

A national policy on maternal and child health/family planning has been defined. Additional work will be needed in order to achieve a comprehensive integrated policy.

## Cost Recovery

A major issue affecting the sustainability of the above areas of intervention is cost recovery through individual or community user fees or through the revenue system. The HSSCS project design correctly calls for close attention to this issue by the PCU.

ANNEX 5

## LES ATTRIBUTIONS DE LA CELLULE DE PLANIFICATION ET SES RELATIONS AVEC LA DIRECTION GENERALE DU PLAN ET DU DEVELOPPEMENT

Dans le souci d'améliorer la gestion des ressources publiques et la capacité d'absorption de l'economie togolaise pour parvenir a une meilleure utilisation des financements utilisables, il a apparu indispensable de creer des cellules de planification au sein des Ministères techniques en vue:

- de renforcer les moyens d'identification de nouveaux projets capables de promouvoir la croissance economique;

- de disposer de moyens de sélection de projets (ou des variantes de projets);

- d'ameliorer la qualite des dossiers de projets à inscrire au Budget d'Investissement et d'Equipement (BIE) ou à presenter aux Bailleurs de Fonds;

- de reduire les délais existant entre l'identification d'un projet et sa realisation;

- de garantir l'efficacité des projets a moyen et à long terme pour une meilleure évaluation de leurs objectifs et de leurs charges récurrentes;

- de constituer un portefeuille de projets;

- de creer un fonds d'études constitue d'une série de projets bien identifies et accompagnés de termes de reference précis.

La cellule de planification sera un organe permanent chargé au sein du Ministere d'un systeme de planification-programmation de toutes les actions tendant à la promotion économique et sociale.

La cellule de planification aura comme principales taches:

- la formulation de recommandations sur la strategie de développement sectoriel et les politiques en decoulant;

- l'identification et la préparation de projets pour les programmes d'investissement en accord avec la strategie adoptée;

- le suivi des projets en cours et la formulation de recommandations pour leur reorientation, si necessaire;

- l'évaluation des projets acheves et la formulation de recommandations pour leur continuation, modification ou élimination.

Placée sous l'autorite directe du Directeur de Cabinet ou du Secrétaire Général, la cellule établira et maintiendra des contacts avec les services techniques du Ministere pour obtenir toutes les informations necessaires à l'accomplissement de ses taches dans le souci d'une meilleure coordination.

Elle rendra compte de ses activites au Ministère par des rapports trimestriels dont copies seront envoyées a la Direction Generale du Plan et du Developpement.

Les membres de la cellule auront par un systeme simple et permanent de suivi à fournir régulierement à la Direction Générale du Plan et du Developpement les indicateurs physiques et financiers de l'execution des projets.

La Direction Générale du Plan et du Développement apportera aux membres de la cellule son appui par des seminaires, des rencontres de concertation à travers un programme cohérent de formation et la mise a leur disposition de documents méthodologiques et de synthèse.

L'UPC en tant qu'embryon de l'organe de planification et de coordination des actions du MSPASCF devra aider a la préparation des politiques sectorielles de développement, des programmes sectoriels, des dossiers de projets et des fiches de projets sur les actions en cours et les actions nouvelles que le Ministère aura a fournir à la Direction Generale du Plan et du Developpement. La recherche de financements implique une bonne coordination entre le Ministère de la Sante Publique, des Affaires Sociales et de la Condition Feminine qui a l'initiative des projets et le Ministere du Plan qui a la charge de verifier le bien fonde des actions proposées, leur intérêt sur le plan économique social et financier et leur coherence avec les objectifs de développement poursuivis et les Bailleurs de Fonds qui sont sollicités pour le financement des operations.

Aussi est-il indispensable que des contacts reguliers, des réunions de concertation, des échanges d'informations et de documents soient instaures entre l'UPC et la Direction Generale du Plan et du Développement

## ANNEX 6

### LISTE DES AUTORITES RESPONSABLES DE SERVICES RENCONTREES PAR L'EQUIPE D'EVALUATION A MI-TERME DU PROJET SOUTIEN AU SECTEUR DE LA SANTE POUR LA SURVIE DE L'ENFANT (DU 17 AU 31 JUILLET 1989)

| No. | Nom et Prénom(s) | Adresse |
|---|---|---|
| 1. | Pr. AGBETRA Aïssah | Ministre de la Santé Publique, des Affaires Sociales et de la Condition Féminine, Lomé |
| 2. | Mr. BINI Kilim | Directeur de Cabinet du Ministre de la Santé Publique, des Affaires Sociales et de la Condition Féminine, Lomé |
| 3. | Mr. WENTLING Mark | Représentant Résidant de l'USAID au Togo, Lomé |
| 4. | Mlle MCLEOD Evelyn | Représentante Adjointe de l'USAID au Togo, Lomé |
| 5. | Mr EHMER Paul | Responsable de Projet Santé et Population à l'USAID-Togo, Lomé |
| 6.. | Dr. SIAMEVI Komlan | Directeur Général de la Santé Publique, Lomé |
| 7. | Mr. BOULI Takouda | Directeur Général des Affaires Sociales, Lomé |
| 8. | Mme AITHNARD Ahlonkoba | Directrice Générale de la Condition Féminine, Lomé |
| 9. | Dr. BARANDAO Bakélé | Directeur Général Adjoint de la Santé Publique, Lomé |
| 10. | Mr. DE SOUZA | Directeur des Services Administratifs et Financiers, D G S P, Lomé |
| 11. | Dr. KARSA Tchasseu | Directeur de la Division de l'Epidémologie, Lomé |
| 12. | Dr. GAYIBOR Anani | Service du Paludisme, Lomé |
| 13. | Dr. E.AKOLLY et 3 membres de l'équipe centrale de SNES | Service National d'Education pour la Santé (SNES), Lomé |

| | | |
|---|---|---|
| 14. | Dr. BIRREGAH Saka | D H R R S, Lomé |
| 15. | Mr. Brian FITZGIBBON | C C C D, Lomé |
| 16. | Mr. SOKPOR | Direction Générale de la Condition Féminine, Lomé |
| 17. | Mr. DELAHAYE Peter | U N I C E F, Lomé |
| 18. | Dr. KABAMBA | O M S, Lomé |
| 19. | Mr. BAMAZE Tchao | Directeur Associé du Corps de la Paix des Etats-Unis, Lomé |
| 20. | Mr. AGBA Akoloum | Directeur de la Division du Développement Communautaire, Direction Générale des Affaires Sociales, Lomé |
| 21. | Dr. SALAMI Latifou | Directeur de l'UPC, Lomé |
| 22. | Mr. OURO-BAWINAY Tchatomby | Coordonnateur National, Volet Santé Communautaire de l'UPC, Lomé |
| 23. | Mr. HOUNGUES Kouami | Coordonnateur National, Volet Appui aux Centres de Santé à l'UPC, Lomé |
| 24. | Dr. FRAZZICA Pina | Chef de la Partie Assistance à l'UPC, Lomé |
| 25. | Mr. M'BAYE Seye | Spécialiste I.E.C. à l'UPC, Lomé |
| 26. | Mr. O'BRIEN Louis | Assistant Technique à l'UPC, Lomé |
| 27. | Mr. TCHACONDO Tchahira | Chef Comptable National de l'UPC, Lomé |
| 28. | Mr. SODOKE Kodjo | Directeur Régional des Affaires Sociales des Plateaux, Atakpamé |
| 29. | Mr. BADJALLA | Directeur Régional du Plan des Plateaux, Atakpamé |
| 30. | Mr. EDORH Ananou | Chef du Service Régional de l'Assainissement des Plateaux, Atakpamé |
| 31. | Dr. NABILIOU | Médecin-Chef Région des Plateaux, Atakpamé |

| | | |
|---|---|---|
| 32. | Mr. NEKERE Manissam | Comptable Régional de l'UPC des Plateaux, Atakpamé |
| 33. | Mr. le Superviseur Régional du Volet Santé Communautaire des Plateaux | Atakpamé |
| 34. | Equipe Préfectorale de Formateurs (4 membres) | Kpélé (Kpalimé) |

# ANNEX 7

## EVALUATION SCOPE OF WORK

### Introduction

The Health Sector Support for Child Survival (HSSCS) project was conceived in response to a need for a planned and more coordinated approach to child survival activities by the Government of Togo (GOT). This was necessary in order to maximize the utilization of scarce resources for the achievement of a positive national impact in a minimum amount of time. The project purpose is to improve the capability of the Ministry of Public Health, Social Affairs and Women's Condition (MPHSAWC) to plan, manage and coordinate the delivery of child survival services in a rational and cost-effective way.

The project agreement was signed 9/7/87 for a life-of-project amount of $4.5 million. To date nearly $4.0 million have been obligated. A technical assistance contract with Development Assistance Coroporation (DAC) was signed on 9/21/88 for an expected life-of-contract cost of $3.5 million. This contract includes $1.3 million in local-cost support for activities to be implemented through the MPHSAWC, in addition to support for two technical experts (one in health planning and one in information/education/communications training). There is one additional technical advisor on a USAID PSC who works with the contractor TA team.

The project consists of three components. The first, the planning and coordination component, is to build a Togolese capacity to plan, budget, manage and coordinate child survival-related activities, through the establishment of a planning and coordination unit (PCU) reporting to the Minister of PHSAWC. The second component, health centers support, focuses on public health staff working at health centers, instructing them in effective interpersonal approaches and adult health education techniques for use with their clients, and in the substance, efficacy, and promotion of child survival measures. The third component, the outreach network, in addition to the second component's instruction of public health personnel, undertakes village outreach activities in two regions of Togo.

### Purpose of the Evaluation

The project authorization required that an in-depth evaluation be undertaken during the twenty-first project month. The purpose is to assess progress to date in accomplishing project objectives, and to determine whether the Government of Togo has demonstrated sufficient commitment to the project to warrant a recommendation for project continuation.

## Evaluation Schedule and Team Composition

The evaluation is scheduled to take place from July 17-29, 1989. Even though the complete technical assistance team has only been in place for seven months, OAR/Togo is sticking to the original plan of holding this evaluation now because we feel that sufficient time has passed to be able to reasonably assess GOT commitment and in particular to measure PCU effectiveness.

The evaluation will be centered in Lome, but at least one field trip will be necessary to assess field activites in training and health education, and in the community development aspects of the project. The initial meetings will be held in Lome, with field activities taking place toward the end of the first week, and with the second week back in Lome devoted to further discussions and report writing.

The team will consist of the Regional Health Officer (REDSO/WCA), a health planner (under an IQC contract), a project development officer to serve as team leader (REDSO contractor), a representative from the GOT Ministry of Health, and a GOT Ministry of Plan representative. The vice president of Development Assistance Corporation will participate during part of the evaluation, but will not be a member of the evaluation team.

## Scope of Work

The following scope of work has been developed between the mission, the contractor, and ministry personnel.

1. General Questions

   a. The degree to which inputs have been provided efficiently;

   b. The degree to which outputs have been and are likely to be realized on schedule;

   c. Overall project management by the grantee, A.I.D., and the contractors;

   d. The need for making mid-course corrections in GOT and technical assistance staffing and management arrangements;

   e. The continuing validity of the project purpose and related objectives in terms of realism, appropriateness, feasibility, and likelihood of sustained beneficial impact;

   f. The degree to which women are able to avail themselves of project benefits and participate in project activities.

2. Project-Specific Questions

a. Planning and Coordination Unit (PCU)

- Assess the GOT and particularly the MPHSAWC commitment to the project in general, and the PCU specifically. This should include an analysis of the effectiveness of the PCU in its planning and coordination function within the ministry in the area of child survival, and an assessment of the extent to which the minister, the three directors general, and other ministry divisions recognize the role and functions of the PCU within the ministry.

- Assess the effectiveness of the PCU in coordinating child survival activities among different donors, including USAID, given the current level of effort.

- Assess the organizational effectiveness of the PCU and its integration into overall MPHSAWC planning activities.

- Explore the issue of the present PCU director's many other responsibilities, and the effect this has had on the functioning of the PCU. Included should be an assessment of the other GOT representatives appointed to the PCU and their effectiveness in the planning/coordination function; and the effect that the non-approval of the MPHSAWC request for salarv supplements for GOT project personnel has had on project implementation.

- Examine the role of contractor technical assistance and determine whether the present configuration of skills best meets project needs.

- Assess the extent to which the PCU has been effective in helping the MPHSAWC rationalize its budget/planning process, and determine whether more resources should be devoted to this issue given the overall project objective.

b. Project Design

- Assess the project design with regard to present realities to determine whether all objectives are still appropriate and can be achieved within the project time frame.

- Examine the appropriateness of combining the conceptual aspects of the planning and coordination function with the operational aspects of the up-country training, health education and community development activities, and whether it continues to be possible to concentrate on both at the same time, with the same limited staff having to handle both. Also

examine the implementation timetable for these two interdependent activities, and determine whether it is still appropriate.

- Determine whether it is still appropriate for this project to specifically exclude child survival service provision aspects given the necessity to demonstrate to ministry personnel that improved planning can have a positive effect on service provision.

c. Contract

- Determine the appropriateness of the present MPHSAWC proposal for construction of a new Division of Maternal and Child Health headquarters, merging $100,000 of project money with $100,000 from the newly approved UNFPA project.

d. Evaluation

- Determine the extent to which baseline data has been or should be collected measure future project progress, given the essentially planning nature of the project. Suggest appropriate benchmarks for measurement of project progress.

e. General

- Determine whether the "child survival" project focus is sufficiently defined to give the project necessary direction and focus. Is the PCU getting spread too thin on too many technical issues to be really an effective tool to improve MPHSAWC planning, and does it make sense to limit the planning improvement function to only child survival?

- Determine the extent to which all conditions precedent as outlined in the project agreement and discussed in the project paper have been met.