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Appendix B. to PB 2 (12.3.87)

AGENCY FOR INTERNATIONAL DEVELOPMENT PROJECT PAPER FACESHEET		1. TRANSACTION CODE <input type="checkbox"/> A: ADD <input type="checkbox"/> C: CHANGE <input type="checkbox"/> D: DELETE	PP
3. COUNTRY/ENTITY (ADO-NIAMEY) TOGO		2. DOCUMENT CODE 3	
5. PROJECT NUMBER (7 digits) [693-0212]	6. BUREAU/OFFICE A. SYMBOL: AFR B. CODE: [06]	4. DOCUMENT REVISION NUMBER <input type="checkbox"/>	
7. PROJECT TITLE (Maximum 40 characters) [TOGO FAMILY HEALTH]		9. ESTIMATED DATE OF OBLIGATION A. INITIAL FY: [77] B. QUARTER: [4] C. FINAL FY: [77] (Enter 1, 2, 3, or 4)	
8. ESTIMATED FY OF PROJECT COMPLETION FY: [81]			

10. ESTIMATED COSTS (\$000 OR EQUIVALENT \$) 2620

A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B. FX	C. L/C	D. TOTAL	E. FX	F. L/C	G. TOTAL
AID APPROPRIATED TOTAL						
(GRANT)	(1158)	(30)	(1188)	(1158)	(30)	(1188)
(LOAN)	()	()	()	()	()	()
OTHER U.S. 1. FPIA				384	161	545
OTHER U.S. 2.						
HQST COUNTRY	25		25		837	837
OTHER COUNTRIES				50		50
TOTALS				1592	1028	2620

11. PROPOSED BUDGET APPROPRIATED FUNDS (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH. CODE		E. 1ST FY 77		H. 2ND FY		K. 3RD FY	
		C. GRANT	D. LOAN	F. GRANT	G. LOAN	I. GRANT	J. LOAN	L. GRANT	M. LOAN
(1) PH	532	510		1188					
(2)									
(3)									
(4)									
TOTALS									

A. APPROPRIATION	N. 4TH FY		O. 5TH FY		LIFE OF PROJECT		12. IN-DEPTH EVALUATION SCHEDULED
	P. GRANT	Q. LOAN	R. GRANT	S. LOAN	T. GRANT	U. LOAN	
(1)					1188		MM YY [01 98]
(2)							
(3)							
(4)							
TOTALS							

13. DATA CHANGE INDICATOR. WERE CHANGES MADE IN THE PID FACESHEET DATA, BLOCKS 12, 13, 14, OR 15 OR IN PRP FACESHEET DATA, BLOCK 12? IF YES, ATTACH CHANGED PID FACESHEET.

1 = NO
 2 = YES

14. ORIGINATING OFFICE CLEARANCE		15. DATE DOCUMENT RECEIVED IN AID/W. OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION	
SIGNATURE [Signature]	TITLE DIRECTOR, REDSO/WA	DATE SIGNED MM DD YY [01 12 77]	MM DD YY [] [] []

TOGO FAMILY HEALTH

Table of Contents

	<u>Page</u>
Part I. <u>Summary and Recommendation</u>	
A. Face Sheet Data-----	i
Table of Contents-----	ii
B. Recommendations-----	1
C. Description of the Project-----	2
D. Summary Findings-----	5
E. Project Issues-----	7
Part II. <u>Project Background and Detailed Description</u>	
A. Background-----	8
B. Detailed Description-----	14
Part III. <u>Project Analysis</u>	
A. Technical Analysis including Environ- mental-----	28
B. Financial Analysis and Plan-----	38
C. Social Analysis-----	43
D. Economic Analysis-----	46
Part IV. <u>Implementation Planning</u>	
A. Administrative Arrangements-----	48
B. Implementation Plan-----	55
C. Procurement Plan-----	55
D. Evaluation Plan-----	57
E. Conditions, Covenants and Negotiating Status-----	60
 <u>ANNEXES</u>	
A. Project Performance Tracking Network---	62
B. Logical Framework Matrix-----	71
C. Project Technical Details-----	76
1. Project Costs-----	76
2. Technical Description of Center---	84
3. Furniture and Equipment List-----	85
4. MOH Personnel-----	92
5. Draft Project Description for ProAg	93
6. Illustrative Curriculum-----	95

Table of Contents (cont'd)
Annexes

Page 2

D. Initial Environmental Examination-----	98
E. Statutory Checklist-----	104
F. Organizational Chart of MOH-----	117
G. Organizational Chart of Travaux Publics-----	118
H. Descriptive Duties of Health Personnel	119
I. Revised Health Sector Assessment-----	120
J. Studies Done-----	121
K. Grantee's Application for Assistance---	122a
L. Social Analysis-----	123
M. FPIA Letters of Proposed Funding-----	143
N. Mission Director's 611(¢) Certification	150

B. Recommendations

- Grant \$1,188,000
- Waiver from Code 000 to Code 941 plus the co-operating country for procurement of construction services.
- Approval of local currency authorization in the amount of \$10,000.

C. Summary Description of the Project

This is an international joint effort between the United States Agency for International Development (AID), Family Planning International Assistance (FPIA), the international division of Planned Parenthood Federation of America, Inc., and the Government of Togo (GOT), particularly the Ministry of Health, Social Affairs and the Advancement of Women (MOH). The project will assist the GOT in strengthening its institutional capacity to provide improved health services to its populace, particularly pregnant and lactating mothers and children 0-5 years of age. With five out of ten children dying before they reach the age of five in rural areas of Togo, there can be little doubt about the need for improving maternal and child health services.

This objective will be accomplished through the in-depth training and/or retraining of medical, paramedical and social personnel of the MOH in the various aspects of family health, i.e. maternal child health, nutrition education and family planning. The project does not address all phases of the Togolese health services, but is limited to provide better training, understanding of and reorientation towards family health to all health personnel.

The project will be implemented under the aegis of the MOH. An AID-financed technician and his Togolese counterpart, the Director of the Family Health Center, will be primarily responsible for day-to-day management and implementation of the project. They will coordinate all donor inputs and monitor project progress and adherence to the conditions agreed upon by all donors.

This is a six year project. However, AID funds will be disbursed over the first three years of the project. The AID contribution will consist of financing for (i) the design and construction of the Center, (ii) furniture and equipment for the Center, (iii) the services of a public health advisor and a bilingual secretary.

FPIA will finance the entire training component of the project. This will include: (i) approximately 29 person months (PM) of short-term technical assistance; (ii) approximately 102 PM of short-term participant training; (iii) commodities and equipment; (iv) some local cost (research funds and a bilingual secretary); and (v) a portion of operating cost (vehicle maintenance and POL)

The GOT contribution will consist of (i) land for the center site; (ii) salaries of full and part-time center staff; (iii) per diem and transportation of trainees; and (iv) operational cost of the center.

The prudent management of the above inputs will produce the following outputs:

- (i) Construction of the Family Health Center;
- (ii) Curriculum developed;
- (iii) Health and sex education materials developed;
- (iv) Approximately 120 senior level and 120 mid-level trainees trained and/or retrained per year starting January 1980.

The Family Health Center will serve as the central facility to offer training to primarily rural-based health personnel who will then be able to offer their newly-acquired skills to the majority of the Togolese population. Training in family health including methods of child spacing for senior level health personnel such as physicians, midwives and nurses requires a combination of clinical and theoretical teaching. Courses have to be of adequate length to assure that the students have mastered new concepts and can carry out new procedures in a competent manner. With the existence of a sufficient nucleus of Togolese personnel, the additional training of key senior health professionals from each of the rural districts will enable them to return to their posts with both teaching and supervisory skills necessary to assure the rapid spread of their new knowledge.

The following conditions are projected to exist at the end of this project:

(i) A Family Health Center will have been constructed and equipped; fully staffed with qualified Togolese personnel; provide in-depth training in the various aspects of family health to medical, paramedical and social personnel as well as quality health services to the population in the Be district of Lome.

(ii) Introduction of family health services including family planning by well trained health personnel

in at least one MCH or health center in each of the 21 health districts of the country.

(iii) The following percentages of MOH personnel will have been trained and/or retrained: (a) 88 percent of doctors; (b) 85 percent of midwives; (c) 95 percent of auxiliary midwives; (d) 100 percent medical assistants and nurses working in rural areas; and (e) 50 percent of social agents/animateurs.

(iv) Sex education materials provided to all secondary schools and additional sex educational materials to all primary schools.

(v) Ten percent of married couples using a modern, contraceptive method within five years of full operation of the Center (i.e., FY 1985).

D. Summary Findings

Health services in Togo, as in most developing countries, have unfortunately attempted to follow the models learned from the industrialized western world. Health personnel have in most instances been educated to provide high technology and hospital based medicine with little emphasis on public health and preventive medicine. However, the developing countries - including Togo - cannot for years, if ever, rely on highly skilled medical doctors to provide health services for the mass of rural population. In Togo, for the near future, most of the health services in rural areas will have to be provided by paramedical and auxiliary health personnel who have very limited training. But the task of reorienting and retraining this personnel in the different - mainly preventive - aspects of family health is not an easy one. Prevention is better than cure, but it is often easier and more gratifying to treat or cure the patient who is sick than it is to persuade people to use simple measures that will prevent them from getting ill. Certain aspects of family health - especially family planning - also require the learning of new technology. In spite of its worldwide use for many years, modern contraceptive technology still at times causes complications. Although the risk of using the "pill" may be many times less in developing countries than the risk of a pregnancy, the complications which occur are often highly publicized and used against the program. Therefore, in-depth training is needed not only to reorient health personnel towards meeting the basic needs of the rural population, but also to avoid complications when using the new technology. Quality training, retraining or reorientation of health personnel, therefore, is a first and basic step needed for improving the health services in Togo.

This project is a low cost preventative approach to medical care. The total cost of the establishment and the running of the center over the six-year life of the project is \$2.620 million. The recurrent cost to the GOT are reasonable and well within the capacity of the MOH to absorb. With the technical assistance to be provided by AID and FPIA, the MOH has the capability to implement this project.

The project is consistent with Section 1.04 of the Foreign Assistance Act of 1961 and meets all applicable statutory criteria.

In summary, the project has wide implications for the direction of Togolese health services for years to come and should contribute significantly to the long-range goal of improving the health of the Togolese populace. It is technically, economically and socially feasible to implement this project as planned.

E. Project Issues

The following issues were raised as the October 1975 ECPR review of the previous project paper.

1. The previous PP did not provide for systematic change whereby the proposed training program would have direct linkages to the delivery of preventative family health/family planning services to the rural sector. The linkages of the proposed training program to the rural sector are discussed in the Part III.A and C of this PP.

2. The previous PP failed to indicate that the GOT is prepared to reorient its policy on the health system to build preventative services to complement its present curative emphasis. The reorientation of the GOT's health policy is discussed in Part II.A. of this PP.

3. The FY 1975 DAP for Togo, Dahomey and the Ivory Coast recommended that there be no large scale AID activities in the health sector unless the GOT health policy is modified to increase emphasis on preventative health and in the provision of health services to the poor majority. The revised Health Sector Assessment of the DAP was submitted to AID/Washington May 13, 1977. This document clarifies the issues raised with regard to the GOT's health policy and provides the framework upon which this PP is based.

4. State 151857 requested that the PP thoroughly delineate the roles of the various participants in MCH/FP training in Togo and show how respective donor contributions are coordinated and mutually supporting. The major concern is that the training strategy proposed by FPIA and the recently approved UNFPA project may not be complementary in every respect. The FPIA training component as well as the relationship between these two projects are explained in the Technical Analysis.

PART II - PROJECT BACKGROUND AND DETAILED DESCRIPTION

A. Background

1. History of Development Problem to Which Project is Addressed.

After independence was attained in 1960, Togolese health services continued to be modeled on the inherited French health delivery system. Generally, this system emphasized curative hospital-based medicine centered in the capital city and larger urban areas. Except for some mass immunization programs carried out with mobile units, little emphasis was given to reaching the rural population with basic curative and preventive health services. Governmental attitudes towards family planning were strongly negative. There was limited concern for the negative impact of rapid population growth on the country's economic development, and little attention was focussed on the problem of too narrow spacing between child births on the health of mothers and children. These attitudes began changing, however, in the early 1970's.

The demographic impact of rapid population on socio-economic development is now clear to Togolese officials, even if acceptable solutions are less evident. Similarly, there is general agreement among health planners of the need for integrating family planning with maternal and child health services for the purpose of better spacing of child births.

As described in the revised Togo Health Sector Assessment of the DAP (attached as Annex I), in the last few years there have been two important developments in the GOT's policies in the health field. First, since 1974 the GOT has changed its emphasis from hospital based medical care, mainly oriented towards the urban population, to a more broadly based policy of taking basic curative and preventive health services to its rural population. The strategy is to replicate in other parts of the country the WHO supported pilot project in the Vogan area described in Part II of this paper. In the Third Five Year Economic and Social Development Plan (1976-1980), this policy is expressed as follows:

"Health and education are among the highest priorities of the plan. The health philosophy is to reach the largest possible number of the population. To obtain

this, the emphasis will be:

- (1) on mobile rather than stationary health workers;
- (2) on village dispensaries rather than sub-division hospitals;
- (3) on renovation and equipping of existing health facilities rather than on new construction; and
- (4) on preventive medicine rather than on curative medicine"

Not discussed in the Third Five Year Economic and Social Development Plan, but receiving increasing emphasis during the past three years is the area of family health. Evidence of this interest includes the recent introduction of sex education in school curricula; the success of the 1976 UNFFA sponsored program on sex education, and recent programs on sexual behavior on Togo TV. GOT senior officials in the Ministry of Health stress the importance of family health in their program. They view family planning for spacing of child births as an important component of improved maternal and infant health.

The revised Health Sector Assessment submitted in May 1977 discusses the health budget in the light of the goals stated above. In spite of the emphasis on mobile rather than stationary health workers and on preventive medicine, about 70 percent of the budget was earmarked for improvement and expansion of stationary health facilities. However, of the money allocated for health facilities, only 20 percent was going for improvement of the CHU in Lome, the rest was being spent on facilities to serve the rural areas. While budget allocations do not meet stated goals, consideration should be given to two additional considerations. Any national health delivery system has to include provision of tertiary care, which in Togo includes the types of surgical and medical services provided only in the CHU in Lome. The rural health facilities being constructed or improved included dispensaries, primary health centers, regional and district hospitals. Even preventive and primary care has to operate from a base, and likewise have a location to refer patients to for secondary care.

The second largest item in the budget for the Five Year Plan was for paramedical education, followed by control of communicable diseases. Sanitation improvements and maternal and child health projects and pharmacy support received the largest share of the remainder. Minimal support was provided for health education and nutrition.

Reference is made to the revised Health Sector Assessment pp.2-5 for a comprehensive statement of Togo's major health problems and their impact on the country's development. Briefly, the most frequent childhood diseases are:

- (1) Acute broncho-pulmonary disease.
- (2) Diarrheas and dysenterias.
- (3) Malaria (all forms).
- (4) Impetigo and other skin diseases.
- (5) Worms and other intestinal parasites.
- (6) Measles.

These diseases account for about 80 percent of childhood morbidity in Togo. Most of the diseases are preventable through simple means such as better housing and clothing of small children exposed to cold and drafts during the rainy season; better sanitation and water supplies; distribution of anti-malaria drugs; more use of soap and water to keep skin clean; use of latrines to avoid infections with intestinal parasites; and immunization against measles.

In Togo more than 50 percent of the women examined at prenatal clinics suffer from anemia, most likely due to poor nutrition, iron and vitamin deficiencies. Intestinal parasites and malaria are among the most common findings in pregnant women. The lack of sanitary water supplies may account for some of these diseases. In 1974 (last available health statistics) there were 48 maternal deaths out of 43,815 deliveries attended by the government health services. About 1,500 pregnancies ended in spontaneous abortions and about 143 pregnancies were terminated through induced abortions. There were 42,106 live births and 1,603 still-births and a total of 826 newborn children died in the maternity wards.

Maternal and infant mortality and pregnancy wastage rates are thus high in Togo as in other West African countries indicating need for expanded and improved maternal and child care services including nutrition and child-spacing.

In the past, other important development priorities such as increased agricultural production, food/nutrition, livestock, have absorbed the major part of scarce development funds. It is only in the last few years that public health has received sufficient priority from the Togolese Government and from external donor agencies. This fact has raised concern in the past as to the GOT's commitment to expand health services to rural areas and contributed to the unusually long and complicated history of the development of this project proposal. Therefore, the following sub-chapters will explain in some detail how this higher priority for health has come about.

2. History and Development Proposal

The history of this project proposal goes back to the spring of 1971 when the then GOT Director of Maternal and Child Hygiene (MCH) first raised with Peace Corps officials the possibility of constructing a demonstration family health planning clinic in Togo. To introduce this new concept of "Family Health", that is family planning as an integral part of MCH for the improvement of the health of mothers and children through the better spacing of children, the MCH felt the need for extensive training or retraining of its medical and paramedical personnel in the different clinical and theoretical aspects of family health. Since no facility existed in Togo which could combine clinical and classroom training needed for this purpose, a request was made to USAID for assistance in construction of a Family Health Training Center in Lome. In June, 1973 AID/Washington approved in principle the financing for the construction of such center (Accra 3963 dated June 21, 1973, and State 124914 dated June 26, 1973).

In December 1973 a contract was made with an American Public Health Association (APHA) consultant to assist the GOT Interministerial Council to develop a comprehensive family health plan (PLAN de Sante Familiale) which included the training of medical, paramedical and social personnel in family health in the proposed center; and training of primary and secondary school teachers in "sex education" for the purpose of introducing this subject in all schools. On the basis of this plan a Project Paper (PP) was drafted and received in AID/Washington on July 28, 1975. However, many questions were raised in AID/Washington regarding inconsistency between the DAP Health Sector Assessment conducted in

1974 and the purpose of the proposed project. The DAP stated that the Togo health sector was oriented towards curative medicine benefiting the urban population. Concern was also expressed about the need for another training institution in Lome; how such Center would benefit the rural population; and about the GOT's true dedication to and real interest in family health including family planning. Furthermore, the plot chosen for the Center was found to be too small and unsuitable for the purpose.

The development of the proposal and resolution of issues did not advance until the arrival of a health team consisting of REDSO Health Officer, the Director and Deputy Director of the regional "Strengthening of Health Delivery Systems" (SHDS) project and ADO/Niamey in Togo in July 1976 to conduct a preliminary study of Togo's health sector and the feasibility of the proposed Family Health Training Center. Basically, the team found that since 1974 the GOT health policy had evolved. In contrast to past policy, the GOT was now putting strong emphasis on reaching the rural population with basic curative and preventive health services. In the new policy setting, the team concluded that the proposed Family Health Training Center in Lome would be complementary rather than competitive to the other health training institutions in Togo and could serve as a model for introducing modern family health concepts in Togo and possibly in other Francophone countries in West Africa. In addition, the GOT had chosen another plot in the Be district of Lome for construction of the Center. The new plot appeared to be satisfactory and is the site chosen for the present project. This site was also determined to be suitable for the purpose by a REDSO contract engineer. Consequently the team recommended that the Health Sector Assessment be updated and that a team be designated to write the Project Paper noting the health team's findings

An APHA team arrived in Lome on March 19, 1977, and spent three weeks in Togo. Their findings generally supported the concept of establishing a "center of excellence" for training of medical and paramedical personnel in family health. The final decision to proceed with the project development was made April 12, 1977 in a meeting attended by the Ambassador, Embassy, REDSO and AID officials. A proposal was submitted to the GOT outlining areas of possible AID assistance and further requirements for development of the Project Paper. The revised Health Sector Assessment was submitted to AID/W on May 13, 1977 to

serve as further reference and background for the Project Paper. A summary of studies done in the context of this project proposal is attached as Annex J

3. Difference Between Previous and Present Project Proposals.

As described in the revised Health Sector Assessment (Section II 2.B) the GOT has taken many steps to promote the concepts of family health or family well-being ("bien-etre familial") including the training abroad in family health care of a cadre of doctors, midwives and nurses. Moreover, the MOH is planning to give short-term courses in family health for its paramedical personnel and auxiliary midwives. Sex education has already been introduced in all primary schools and will soon be introduced in all secondary schools. These developments are reflected in the present Project Proposal (PP). The emphasis of the redesigned project will be on clinical and classroom in-depth training of medical and paramedical personnel and on the extension of the outreach of family health services to all health districts and through them to the rural population. The technical assistance to the Ministry of Education proposed in the first project paper is not envisioned. AID technical assistance proposed in the present PP will be limited to one public health advisor/administrator to assist in the management of the Center, development and revision of curriculum and training of his counterpart and trainees at the Center. Since the submission of the 1975 PROP, costs have increased considerably. Thus the Center will absorb the major part of AID financial support to the project.

In order to insure that all parties involved are in agreement with the above changes, the REDSO health team drafted a project proposal including a logical framework matrix, budget estimates and a floor plan of the Center. This proposal was officially submitted to the Ministry of Health on May 3 and approved on May 18, 1977 (Lome 1334). To demonstrate the GOT interest in this proposal the Minister of Health transmitted to AID/Lome a letter (May 31, 1977) endorsing this proposed project. This letter is attached as Annex K and constitutes the GOT's (Grantee's) application for assistance. It should be noted that FPIA is now a major donor in the project which was not envisioned in the GOT's application for assistance.

B. Detailed Description

1. Togo's Rural Health Delivery System

The Togo health delivery system is based on the WHO health support system introduced in the pilot zone of Vogon in 1965. However, it was not until 1974 that the GOT put substantial effort into replicating this system in other parts of the country. The system has a pyramidal model. Regional and sub-regional hospitals are at the top; circonscription or district health centers are at the next level; and rural dispensaries, staffed by nurses and auxiliary midwives, are at the next level. Finally, at the base of the system, there are the itinerant health personnel (agents itinerants) who provide the basic link between the rural population and the government health services. The itinerant personnel visit all households in the different villages in their areas once a month and provide preventive and non-catastrophic curative health services to the villagers. The auxiliary midwives and itinerant health personnel play crucial roles in health surveillance and referrals of patients to the nearest regional or sub-regional health facility. In Togo, such facilities are rarely more than six miles away.

The auxiliary midwives (matrones) and itinerant health personnel are young women and men with at least six years of primary school. They are chosen on a competitive basis, preferably from the village or district in which they will serve. The auxiliary midwives receive six months of midwifery training in Lome followed by six to twelve months of practical training in the Vogon district under supervision of senior midwives (Diplome d'Etat). The itinerant health personnel receive three months of theoretical training in basic aspects of hygiene and sanitation, recognition of major communicable diseases, nutrition, first-aid and the treatment of certain common diseases, e.g. malaria and leprosy.

There is an obvious need for continuing short-term training and refresher courses for these two categories of health personnel. This problem is exacerbated by the relative scarcity of supervisory personnel to support them. The supervisory chain of command extends from medical personnel in regional and sub-regional hospitals and primary district health centers down to paramedical personnel (nurses and midwives) who staff the secondary health centers and rural dispensaries. The paramedicals in turn are responsible for supervising the auxiliary

midwives and itinerant health personnel. In practice, adequate supervision of auxiliary midwives and itinerant health personnel is clearly difficult to maintain with obvious consequences for the efficiency and effectiveness of medical care at the base of the health delivery system.

2. The Goal

The goal of the project is to improve the health of the Togolese populace with particular emphasis on the most vulnerable group: pregnant women, lactating mothers, and children in the 0-5 years age group. This group is specifically vulnerable to the vicious cycle of malnutrition, high incidence of parasitic and communicable diseases leading to exceedingly high perinatal and child mortality rates. These factors are inducive to high fertility rates because of the desire of the families to replace the loss of their children. Since this often results in too narrow spacing between childbirths, and consequent dangers to the health of mothers and children; it further contributes to the vicious cycle.

In the context of this project, "family health" or "family well-being" is defined as the concepts of integrating preventive and curative maternal and child health services with nutrition education and family planning for the purpose of better spacing between childbirths. Thus, in spite of name, family health does not directly serve all members of the family but is primarily limited to women in the reproductive age group of 15-44 years and children 0-5 years of age.

By concentrating its efforts on improved family health throughout the country the MOH expects to:

- (1) decrease the high perinatal and child mortality rates;
- (2) decrease the incidence of parasitic infections and preventable communicable diseases;
- (3) improve the nutritional status of mothers and children; and
- (4) attain better spacing between childbirths.

However, experience has shown that substantial improvements in these areas are long range goals which will hardly be measurable on a countrywide basis within the short life span of this project. Therefore, special studies and sample surveys of socio-demographic and epidemiological data will be needed as a means of verification of progress toward attainment of the goal. During the life of the project,

such studies will be carried out in the Be district of Lome which will be the first beneficiary of the project's clinical services and thus the first district expected to show improvement of vital data before the project can demonstrate its desired countrywide impact. However, in no way should this be construed to mean that the project's goal is limited to improving the health of the population of the Be district in Lome. Through the outreach effect of the project, the goal is nationwide improvement of the health of mothers and children. The limited surveys in the Be district will be supplemented during years three and four of the project with socio-demographic and epidemiological sample surveys in rural areas in the different regions of Togo, particularly in areas where trained personnel have returned.

The important assumptions for achieving the goal are: (1) the GOT, particularly the Ministries of Health, Education, Finance and Plan will continue to give support to the policy and strategy of extending family health services to Togolese families throughout the country; (2) the GOT will continue giving support to improving its rural health delivery system including activities in the nutrition field; demographic data collection, storage and use; improved access to safe water; the epidemiological surveillance system; and strengthening middle level health personnel in management of health facilities on regional and sub-regional levels; and (3) other factors such as drought, famine, will not upset the expected benefit of improved family health, education and services.

3. The Purpose

The purpose is to strengthen the GOT's institutional capacity to provide improved family health services to its populace, particularly pregnant and lactating mothers and children 0-5 years of age in rural areas, through in-depth training of medical, paramedical and social personnel in various aspects of family health (maternal child health, nutrition education and family planning). Accomplishment of the purpose will require consistent application of improved standards and procedures for delivery of care and information, as well as a better flow of information from medical, paramedical, and social personnel to the general public concerning the concepts and practices of family health. Improved information is required to motivate

the general public to seek the services which the Ministry intends to expand and improve.

The MOH has for some time recognized the need for training and reorientation of its medical, paramedical and social personnel as a means of accomplishing the project purpose. Training is required to increase the understanding among such personnel regarding the various elements of family health and their relationships. Training is also important to motivate such personnel to deliver high quality care and information pertaining to preventive family health. The Ministry has already trained abroad a nucleus of physicians, and midwives, social agents/animateurs and health educators. This group will constitute the core of trainers for extension of family health training to its medical, paramedical and auxiliary health personnel and social agents/animateurs. It has already begun to introduce this kind of training to its personnel, largely in the form of short courses designed primarily to motivate, but also to provide limited amounts of information concerning the concepts and practices of integrated, preventive health care for the family. One example of such training is the short course which was offered to auxiliary midwives during late 1975 and early 1976 sponsored by the Pathfinder Fund. Another example are the many short courses which the MOH will offer in conjunction with the United Nations Fund for Population Assistance (UNFPA) over a period of one and a half years beginning in July 1977. While these programs will perform important educational, orientation functions, they are not likely to be sufficient by themselves for the task of accomplishing the project purpose since this training takes place in conditions which do not permit the necessary combination of theory and practice, nor do they provide sufficient time for trainees to absorb the new information and techniques.

Additional training is required in a setting which combines clinical and classroom facilities and which provides courses of sufficient length for students to master the new concepts and practices which are presented. The MOH, therefore, proposed that a Center of Family Health be constructed to offer training and retraining of personnel and serve as a model for the delivery of quality family health services. The GOT has stated that because of the sensitivity of the subject, family planning work should begin in the capital. Therefore, the Center will be established in the Be district of Lome, a densely populated semi-urban low income area.

A large part of the population are migrants from rural areas and may therefore serve as prototypes to represent the conditions and problems which trainees will meet when they return to their health posts.

Given the number of the different types of personnel who will benefit from training in family health (see revised Health Sector Assessment pp.12 and 13) and the limited capacity of the Center (discussed in the Technical Analysis of this PP), it is obvious that it will not be possible to give in-depth training to all personnel who might benefit from it. Therefore, the emphasis will be on selecting small core groups of senior personnel with supervisory responsibility from each health district for training. These cadres will in turn pass their training experience on to the personnel they supervise. By giving priority to "training the trainers" the project will have a better multiplier effect and a greater opportunity for reaching a major part of the rural population.

While the different classes of trainees will have different needs in accordance with the role they will play in the health team, there is also need for emphasizing the team approach. Thus, the grouping of the different types of trainees will be important. To the degree possible part of the training program will include mixed classes with doctors, midwives, nurses, social workers, in order that each type of trainee will better understand and learn his particular role in the team. Therefore, the curriculum of the training program will have to be flexible. To a certain degree the Family Health Training Center represents a new and experimental approach to reorienting health services towards family health with emphasis on providing basic preventive health services to the largest possible part of the population. There is no set of fixed rules to obtain this result. Progress will best be attained through the practical experience learned from trials and errors.

The Center will be complementary rather than competitive to already existing health training facilities in Togo. In addition to its functions of training and re-training the different types of personnel already employed by the MOH, the Center will provide a clinical training ground for medical interns at the Togo University Hospital Center, nursing and midwifery students and social agents/ amateurs from the Togolese paramedical schools. This

underlines an important function of the Center. After two years of theoretical training, nursing and midwifery students spend one year of practical or clinical training in the field under supervision of senior nurses and midwives. However, in order for senior personnel to guide their students and provide the type of training and supervision in family health that will contribute to the attainment of the project purpose, there is special need for in-depth and quality-controlled training in different aspects of family health. Since no institution exists in Togo where such training can be done, the alternative would be to send senior nurses and midwives abroad. To attain the project purpose, this alternative would be both impractical and more expensive than the establishment of the Family Health Center.

In view of the Center's role to serve as a model and to set high standards for delivery of care and information within the context of realistic, appropriate technology, the broad objectives of the training programs will be to encourage and train the medical, paramedical, and social personnel to use the techniques necessary to provide care and information which will attain desired standards. The objectives must be defined in accordance with the role each particular type of trainee will play in the health team and their particular background. In each case the objectives should be job specific. This is particularly true in Togo where paramedical personnel often are working in rural areas with only remote supervision from medical personnel. They have to take responsibility for and carry out tasks that under more favorable circumstances would be performed by more skilled personnel. This again underlines the need for flexibility in the training program. Staff and trainees at the Family Health Center will have to work together to review standards and practices and to improve them wherever appropriate and possible. Systems for keeping medical and social service records will also be reviewed and revised as necessary by the Center staff to ensure they provide the information required to verify desired practices are being followed. The staff and trainees at the Center will also collaborate to produce and refine instructional materials for use in the Center and also for the trainees when they return to the field. The Center will serve as a focal point and stimulus for research concerning traditional practices of family health and particularly child spacing.

Although small in financial terms the amount requested to support the Center's applied research activities

may be one of the most important and efficient contributions. This will enable the Center to conduct small research studies as opportunities occur without going through time-consuming red tape. The FPIA financed research and evaluation officer will assist in the identification and implementation of research/evaluation studies. Some examples are studies on traditional contraceptive devices and practices. Small socio-demographic studies on knowledge, attitudes to and practice of family planning (KAP studies) will also be introduced in nearby areas and may need only limited funds for logistic support. These studies would have the dual purpose of strengthening the analytical capability of the trainees and providing valuable information on which to base the evaluation of the training program. These studies may lead to proposals for more extensive research to be financed from AID/Washington or REDSO/WA research funds. Thus, the research funds granted to the project could be considered "seed money" which might lead to important research indications.

Besides the above functions the Center will educate and motivate the public to understand, accept and practice family health. Thus, the experience of the Center will be utilized to design and improve educational and motivational materials for public use. The Center will also cooperate with the Ministry of Education for the development of "sex education" materials for use in primary and secondary schools. When not being used for training health personnel and social agents/animateurs the auditorium at the Center can be used for conferences, workshops and seminars attended by primary and secondary school teachers, other governmental officials, private citizens and/or organizations interested in family health.

End of Project Status: FY 77 to FY 84

(1) A Family Health Center will have been constructed and equipped; fully staffed with qualified Togolese personnel; provide in-depth training in the various aspects of family health to medical, paramedical and social personnel as well as quality health services to the population in the Be district of Lome.

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

(3) The following percentages of MOH personnel will have been trained and/or retrained: (a) 88 percent of doctors; (b) 85 percent of midwives; (c) 95 percent of auxiliary midwives; (d) 100 percent medical assistants and nurses working in rural areas; and (e) 50 percent of social agents/animateurs.

(4) Sex education materials provided to all secondary schools and additional sex educational materials to all primary schools.

(5) Ten percent of married couples using a modern contraceptive method within five years of full operation of the Center (i.e., FY 1985).

The major assumptions for attainment of the purpose are: (1) the MOH will provide qualified staff and other resources necessary to carry out all functions of the Center at the appropriate time; (2) trainees will effectively utilize their new skills; (3) trainees will be returned by the MOH to rural health posts in the field; and (4) family health concepts will be accepted and utilized by the Togolese populace.

4. Outputs

The major outputs of the project are the design and construction of the Center, the participants who receive U.S. and third country training, and the trainees who return to their health post in the field to practice their new skills. It is estimated that approximately 120 senior level trainees with supervisory responsibilities will be trained and/or retrained per year starting early FY 1980. Approximately 120 mid-level trainees are expected to be trained per year and lower level trainees will be trained on an as needed basis. While it is expected that the majority of MOH personnel will be trained within the six-year life of the project, there will be a continuous flow of students from the Togo University Hospital Center and the Togolese paramedical schools beyond the life of the project. Trainees are discussed in more detail in the Technical Analysis.

Another output of the project will be the production of educational materials on family health training for the use of trainees; sex education materials for use in primary and secondary schools; and educational materials such as illustrated pamphlets, films, filmstrips, to be used for education and motivation of the

public to accept and practice family health.

The actual production of sex education and family health educational materials will not take place at the Center but at the Division of Health Education, Ministry of Health. The head of this Division has been one of the leaders in introducing the concepts of family health to the public especially through mass media, radio, TV, etc. The Division has basic photographic, film and reproduction equipment for the purpose. However, its productivity has been limited by lack of staff and materials. Peace Corps has assigned one volunteer to assist this Division in designing family health educational materials and FPIA will finance the costs of the needed materials, films, paper, printing, etc. The family health educational materials produced by the Division will be tested at the Family Health Training Center and improved as needed before they will be produced in large numbers for country-wide distribution.

While the health services provided to the population of Be district may be considered additional benefits of the project rather than primary outputs, the numbers and types of health services provided by the Center will nevertheless be factors in the evaluation of the project's accomplishments.

However, the outreach of the Center to the Be district and its indirect link to the rural population is the single most important part of the project. This is discussed in the Technical and Social Analyses.

The important assumptions for achieving outputs are: (1) sufficient numbers of the different types of health personnel will be available and released from their current duties for the duration of their training or retraining courses; and (2) trainees will be carefully selected in accordance with priorities and criteria established by the MOH.

5. Inputs

To secure the outputs described in the foregoing sub-section, the project will depend on timely and well coordinated inputs from all donors (i.e. AID, FPIA, GOT and possibly UNFPA. The inputs by donor are as

(a) AID

The AID contribution totals \$1,188.3 million. This amount will be disbursed over the first three years of the project. The categories are as follows: (i) the design and construction of the Center (\$839,000), (ii) furniture and equipment for the Center (\$149,300); (iii) the services of a public health advisor/administrator for approximately 24 person months (PM) who will serve as counterpart to the Togolese Center Director (\$180,000); and (iv) a bilingual secretary for the Public Health Advisor (\$20,000 for approximately 24 PM).

(b) FPIA

The FPIA contribution totals \$544,000. This will include the cost of: (i) approximately 29 PM of short-term technical assistance in various health fields to develop curricula and training materials and ensure desirable high standards of the training programs to be offered by the Center (\$180,000); (ii) approximately 102 PM of short-term (3 months) participant training of selected MOH personnel who will either staff the Center or assume top supervisory responsibility for the family health program in their region, circonscription, or district (\$69,500); (iii) commodities, health and sex education materials and supplies (\$210,000); (iv) some local cost (i.e. secretary and research funds (\$70,000); and (v) a portion of operating cost (i.e. vehicle maintenance and POL (\$15,000).

(c) GOT

The GOT contribution totals \$837,200 over the six year life of the project. The categories are as follows: (i) land for the Center site (\$25,000); (ii) per diem and transportation costs for trainees (\$110,100); (iii) personnel to manage and operate the Center (\$459,100) and (v) operating cost of the Center (\$243,000).

(d) UNFPA will be asked to consider financing of three passenger vehicles for the Center staff to facilitate follow-up and supervision of trainees who have returned to their rural post. A figure of 50 thousand dollars has been included in the budget for this purpose. This figure also includes financing of mobylettes and

bicycles for itinerant health personnel to help strengthen the outreach of this project. Discussions on the UNFPA contribution began the week of July 30, 1977 in Rome.

The following table provides a summary of inputs by year of allocation.

TABLE I - INPUTS BY TYPE AND YEAR OF ALLOCATION - US \$000

I. <u>AID</u>	<u>FY 77</u>	<u>FY 78</u>	<u>FY 79</u>	<u>FY 80</u>	<u>FY 81</u>	<u>FY 82</u>	<u>FY 83</u>	<u>TOTAL</u>
A. Design/Construction of Center	839							839
B. Public Health Advisor/Administrator	180							180
C. Furniture and Equip for Center	149.3							149.3
D. Bilingual Secretary	20							20
TOTAL AID	1188.3							1188.3
II. <u>FPIA</u>	<u>FY 77</u>	<u>FY 78</u>	<u>FY 79</u>	<u>FY 80</u>	<u>FY 81</u>	<u>FY 82</u>	<u>FY 83</u>	<u>TOTAL</u>
A. <u>Short-Term Technical Assistance</u>								
Research/Evaluation			6	12	12	6		36
Family Health/Curriculum Development			12	18	12			42
Education Mot. Development			12	12	6			30
OB-GYN			6	12	6			24
Nurse Midwife			12	18	12			42
Honorarium (Guest Lecturer)				2	2	2		6
B. <u>Participant Training</u>	16.4	27.2	16.4	9.5				69.5

	<u>FY 77</u>	<u>FY 78</u>	<u>FY 79</u>	<u>FY 80</u>	<u>FY 81</u>	<u>FY 82</u>	<u>FY 83</u>	<u>TOTAL</u>
C. <u>Commodities</u>								
(1) MCH-FP Equip. for 8 exam. rooms & audio visual equip.			25					25
(2) Health & Sex Education Materials and Supplies			25	25				50
(3) Contraceptive Supplies				10	15	20		45
(4) Family Planning Kits				20	30	40		90
D. <u>Local Cost</u>								
(1) Research Funds				20	20	10		50
(2) Bilingual Secretary				10	10			20
(3) Vehicle Maint. & POL				5	5	5		15
TOTAL FPIA		16.4	125.2	180.4	139.5	83		544.5

III. <u>GOT</u>	<u>FY 77</u>	<u>FY 78</u>	<u>FY 79</u>	<u>FY 80</u>	<u>FY 81</u>	<u>FY 82</u>	<u>FY 83</u>	<u>TOTAL</u>
A. Land: Center Site	25							25
B. Training: Per diem & transport of trainees				23.4	26.7	30	30	110.1
C. Personnel			22.6	74.4	109.1	120	133	459.1
D. Operational Cost: Medicines, supplies, pharm., maint. of Center and vehicles			5	47.5	59.5	63.5	67.5	243
TOTAL GOT	25		27.6	145.3	195.3	213.5	230.5	837.2
UNFPA: Vehicles, mobylettes, bicycles			50					50
TOTAL UNFPA			50					50
GRAND TOTAL	1213.3	16.4	202.8	325.7	334.8	296.5	230.5	2620.0

The assumption for achieving the inputs are: (a) timely agreements between all donors; (b) technically competent, French speaking technicians are secured; and (c) timely delivery of services and commodities agreed upon by all donors.

PART III. PROJECT ANALYSES

A. Technical Analysis Including Environmental Assessment

1. Technical Feasibility

In anticipation that the proposed Center would be built two years ago, a cadre of Togolese health personnel was trained in the U.S. and other third countries to staff the Center. From this cadre and other trained health personnel, the following persons will be selected by the MOH as core staff for the Center:

- full-time director
- part-time OB-GYN specialist, a pediatrician and a general medical practitioner
- 1 evaluator/researcher
- 4 midwives
- 3 nurses
- 2 social agents/animateurs
- 2 health educators (agent technique)
- 1 laboratory technician and 1 assistant
- 1 pharmacy technician and 1 assistant
- 1 librarian
- support staff (secretaries, record clerk, janitors, etc.)

EPIA will provide approximately 29 person months of short-term technical assistance over the first five years of the project. The specialties envisioned are: a) family health/curriculum development; b) OB-GYN; c) nurse-midwifery; d) education materials development; and e) research/evaluation.

Prior to opening of Center, FPIA consultants will design an in-service refresher course for the core staff. The GOT will provide a temporary training facility for this in-service training. In addition FPIA will finance approximately 102 PM of short-term participant training principally in Africa and in the U.S. The Center Director and the evaluator/researcher will receive approximately three PM of U.S. training in clinical management and research/evaluation respectively. Other participants will include selected top supervisory and middle-level personnel, members of the core staff and 20 midwives for specialized

training and upgrading of professional skills.

In collaboration with the MOH, FPIA consultants will also identify Togolese resident experts and professors in the fields of preventive medicine, community health, maternal and child health care, nutrition demography who will be used as guest lecturers to supplement the core staff.

An illustrative curriculum is attached as Annex C6 . This curriculum will be modified in collaboration with the core staff by FPIA consultants prior to the start of the first training cycle. The same personnel will also develop other curriculum and educational materials to be used during the different training cycles.

Since all personnel who will attend training courses at the Center already have some background in health sciences in accordance with their particular categories, the training will mainly be practically oriented. It is important in this context that all students receive a basic course in the concepts of family health and their relationships. Besides the health aspects of this interrelationship, the course will emphasize the basic socio-demographic aspects of population growth. In addition to the practical and classroom aspects of family health (prenatal care, post-natal care, infant care, child spacing, nutrition, control of communicable diseases, sanitation, personal hygiene), the training programs will emphasize techniques of health education. That is, how to motivate people, how to bring about community participation for improvement of health in the village, and how to evaluate progress and problems. In other words, the training will be aimed at making the students more public health oriented, helping them to better understand the health needs of the rural population, and how to meet these needs by mutual trust and understanding by working together. By emphasizing these principles, the training programs to be offered by the Center will have a substantial impact on the students' orientation towards public health and preventive medicine and thus influence the health services to change their emphases in this direction.

The Family Health Center will include clinic facilities for: a) pre-and post-natal examinations and consultations; b) child spacing consultations and treatment; c) examinations and treatment of problems of

infertility; and d) pediatric consultation and well-child care including immunizations, nutrition control and nutrition education and laboratory and pharmacy facilities. The educational facilities will include two classrooms to accommodate 20 persons each and an auditorium with audio-visual equipment for conferences, lectures, seminars and workshops, a lounge for students, a library and offices. While the clinical facilities will be designed for easy and efficient flow of up to 200 patients a day, efforts will be made to limit the numbers to allow time for quality examinations and treatments. For further details on the physical facilities of the Center see Annex C2.

The training can be divided into two segments: retraining and training in additional skills. The in-service training programs for senior level staff will last about one month and consist of both classroom and clinical training. The maximum size of class which can be accommodated at one time is restricted by the clinical facilities. With eight examining rooms, twenty persons in one group seems reasonable. Separation of different categories of personnel is usually desirable for the classroom portion, but the team approach to clinical care gives everyone a better awareness of the roles and functions performed by each member. Less demanding training for mid-level personnel and students at the medical or paramedical schools could be scheduled in alternate months.

The following table provides an estimate of the number and different categories of personnel to be trained at the Center. It should be noted that for student training, the number of students, types of training, length of courses and curriculum will be worked out between FPIA MOH and the administrators of the individual schools.

TABLE II - Estimate of Numbers and Categories of Trainees and Duration of Courses

Senior Level		1 Month Training - Classroom and Clinical			
Category	<u>1980</u>	<u>1981</u>	<u>1982</u>	<u>1983</u>	
Physicians	5	10	10	10	
Midwives	40	40	50	50	
Nurses and Medical Assts	35	50	60	60	
	—	—	—	—	
Total	80	100	120	120	
Mid-Level		1-2 Week Training - Classroom and Some Clinica			
Auxiliary Midwives	80	80	80	80	
Social Agents	40	40	40	40	
Lower Level		Variable Length - Classroom Only			
Technical Agents					
Auxiliary Nurses					
Traveling Nurses ("Agents Itinerants")		As Needed			
School Health Instructors					
		Student Training			
Category	<u>1980</u>	<u>1981</u>	<u>1982</u>	<u>1983</u>	
Medical Students and Interns	10	20	20	20	
Midwives	30	30	30	30	
Medical Assistants (including nurses)	70	70	70	70	
Auxiliary Midwives	40	40	40	40	
Social Agents	20	20	20	20	

Physician training is scheduled for five persons the first year of operations and ten thereafter. Since there are only about forty physicians working for the MOH who are not either attached to the University Hospital (CHU) or employed in an administrative capacity, this would be sufficient to train almost all the physicians. One important part of the physician training should be the roles and functions of the physician supervising paramedical personnel rendering family health care. The inclusion of a physician in every one month course would strengthen the program. Classroom work for physicians could consist at least in part of self-instructional materials-articles, films and slides.

Midwives could attend the course in groups of six. This size seems appropriate for good clinical exposure, yet large enough that approximately 85 percent of the midwives employed by the MOH will have been trained within four years of Center operations.

At the moment there are only about fifty medical assistants employed by the MOH, so it should be possible to extend training to them within the first three years of Center operations. Nurses giving primary care in rural areas can be included as identified to a maximum of sixty during the fifth year of the project. It is not known how many of the over 500 state certified nurses are giving primary care.

The two categories of personnel who may require classroom training with a small amount of supervised clinical experience are the auxiliary midwives and the social agents/animateurs. Probably a one to two week training period would be sufficient. There are over 300 auxiliary midwives employed by the MOH, and their short-term in-service training may be more appropriately carried by the UNDP funded programs given in regional centers.

Classroom training of variable lengths can be carried out with the lower level health personnel utilizing either one classroom, the auditorium or both. This will not interfere with senior level students receiving in-service training. However, there must be coordination in the use of the teaching facilities by lower level health personnel receiving in-service training and students attending some selected topics and training at the Family Health Center. Use of the

auditorium in the evening may be particularly appropriate for groups such as school teachers being exposed to techniques of teaching sex education.

The numbers given in Table II for student training represent the maximum size of a class enrolled or expected during the four years for each type of school.

Generally there will be approximately six in-depth training cycles per year. The phrase "in-depth training" is used in a relative sense. The short courses for auxiliary midwives and paramedical personnel sponsored by the Pathfinder Fund and the UNFPA are usually in the form of 2-3 day seminars or workshops which are basically orientation and educational in nature. In comparison, the four week courses to be offered by the Family Health Training Center will be relatively long and more intensive.

By allowing one month in between training cycles, there will be adequate time to alter the training curriculum and for staff members to provide crucial follow-up, supervision and technical assistance to graduates working in the field. Follow-up is especially important within two months of a trainee's graduation from the Center. It provides instant feedback on whether graduates are utilizing their newly acquired skills; and it allows follow-up by staff to provide technical assistance where required as well as offering an opportunity to reinforce everything taught in training.

Trainees will be selected by the MOH from rural health posts throughout Togo. Criteria for their selection, to be developed by the MOH, will be subject to change based on the practical experience of the staff and students. The number of students to be trained and/or retrained at the Center will be constrained by the capacity of the Center and its staff to provide the necessary supervised clinical experiences needed for quality training. In addition, there is a limit to the numbers of scarce health personnel who can leave their health posts in the field for longer periods of training without jeopardizing the health care in their districts. The selection of trainees will be influenced by these two factors and by the objective of providing types of training best suited to meet the particular needs of individuals.

The question of whether the personnel will return to their rural health post poses no real problem.

They are employees of the MOH, selected from their rural posts and have no choice but to return when so directed

The entire training component is hinged on timely completion and equipping of the physical facility.

2. The Indirect Link Between the Center and the Rural Population.

Only through the linkages of this project to the population will it be possible to achieve the overall purpose of bringing better family health services to the largest possible number of the rural poor. In practical terms this means that the trainees at the Family Health Training Center will effectively practice their newly-learned skills when they return to their health posts. As stated earlier, this depends to a certain degree on circumstances on which this project has no direct influence. There are, however, certain conditions necessary to reach the ultimate beneficiaries which this project can and will support. These conditions may be summarized as follows:

(i) The first condition is the careful selection of the trainees. By giving priority to training core groups of supervisory personnel from each of the 21 different health districts, the project will develop linkages to reach the rural population.

(ii) Secondly, the training must be directed at giving the trainees sufficient self reliance in order that they feel secure in practicing their new skills. Through the combination of clinical and classroom in-depth training the Family Health Training Center will meet this condition.

(iii) The third condition is availability of clinical facilities and equipment. Through the UNFPA supported project described in the next sub-section, one MCH Center in each district will be fully equipped with family planning materials thus allowing immediate availability of this important aspect of family health to all 21 health districts. However, as the number of fully-trained personnel increases there will be need for equipping more health centers and dispensaries with basic family planning materials. As stated in the revised Health Sector Assessment, improvement and equipment of rural health centers

are among the high priorities in the Five Year Plan. Furthermore, senior health personnel returning to their rural post will be provided with "Family Planning Kits" which will include pharmaceuticals, MCH and family planning supplies.

(iv) The importance of educating the public in family health and motivating them to accept the family health services offered by the MOH can hardly be overstated. With its emphasis on introducing sex education in all primary and secondary schools and educating the public through mass media, radio and TV, etc., the GOT has already taken big steps in this respect. Through the production of educational family health materials, this project will support and sustain these efforts and thereby help prepare the basis needed to reach the rural populace.

(v) Supervision of the trainees after they have returned to their posts is another important condition for obtaining the desired spread effect. To the degree possible, members of the teaching staff will visit their former students between training cycles to observe and ensure that they perform their new skills correctly.

Another important factor in reaching the ultimate beneficiaries is that a critical mass of health personnel will be trained. If the project can attain the reasonable trainee targets given in the logframe, over 300 senior health personnel with supervisory responsibility will have been trained within the first three years of operation of the Center and 120 each year thereafter. At this rate, practically all supervisory and middle level personnel will have been trained within the six year life of the project. The spread effect is discussed further in the Social Analysis.

3. Relation to Other Donor Projects

UNFPA

During the development of the PP, the REDSO team has been in close contact with the United Nations Fund for Population Activities (UNFPA). The UNFPA has finalized an agreement with the GOT to support short-term training courses in family planning for medical and paramedical personnel in the different regions of Togo. This agreement also provides for family planning equipment and materials for one MCH Center in each of the 21

health districts in the country.

According to the UNFPA representative in Dakar, this project was originally conceived by the GOT as a kind of "stop-gap" measure in order to get started with some family health training rather than waiting for the admittedly long-time U.S. decision to support the proposed Family Health Training Center.

While the curricula for the different training programs offered by the UNFPA project are not completely developed at the time of this writing, it appears that there might have been some problems concerning the objectives of the UNFPA and this project. Because of the uncertainty of the approval of the U.S. project, the UNFPA originally planned to train core groups of medical, paramedical personnel to actually perform family planning services, IUD insertions, etc. in the field. However, this training would have been carried out by extremely short-term courses and without adequate clinical training facilities and might thus, in the opinion of experienced health personnel, have been more harmful than beneficial to the introduction of family health in Togo. However, the UNFPA representative has pledged his full support to and cooperation with the Family Health Training Center, and wishes to develop the curricula of the UNFPA project in such ways that the training programs will be preparatory and or complementary to the training to be conducted at the Family Health Center. Certainly this will require very close coordination and cooperation between responsible officials of the two projects. Based on previous excellent cooperation with the UNFPA this can be done. Another point may also be made. The UNFPA project will be about to terminate at the time when the Family Health Center will be in full operation. Therefore, even if the UNFPA project should succeed in providing some in-depth training to some personnel, there will still be a great need and demand for the training programs offered by the Center.

WHO Center

The Center will also be complementary to the WHO-sponsored Regional Training Center in Lome (Centre de Formation, OMS). This Center gives 7-10 weeks training in public health administration for doctors, midwives, nurses and health inspectors from Francophone West Africa. Each course is attended by some 20 senior

health personnel selected by the different countries. The training is theoretical and problem oriented. During the training the students spend time in the field for observation and analysis of different health facilities in Togo and in the pilot health project area in Vogan. These trainees will visit the Family Health Center where many of the students will have their first experience with the integrated approach to maternal and child health, nutrition education, and family planning. The Family Health Center will thus have an important function as a demonstration center for Francophone West Africa and hopefully will stimulate the interest of senior health personnel in the various aspects of family health. The regional WHO-AID supported project, "Strengthening of Health Delivery Systems (SHDS)" is planning, under Phase II of the project, to give technical assistance to the WHO Training Center for the development of training curricula. The SHDS has expressed great interest in cooperating with the Family Health Center, not only for the purpose of exposing the WHO students to clinical family health services, but also to promote the understanding of and interest in family health in other Francophone West African countries.

4. Project Costs

A REDSO engineer has examined the engineering and construction components of the project and found the cost estimates and conditions of construction for the building found in Annex to be reasonable and acceptable, and considers the requirements of Section 611(a)(1) to be satisfied. An itemized cost list including an explanation of costs is attached as Annex C1.

5. The Initial Environmental Examination is attached as Annex D

B. Financial Analysis and Plan

The project presently has three major participants, with some additional resources being provided by the UNFPA. The latter agency might be interested in an expanded role in the future. The present financial participation is projected in the following chart:

<u>Participant</u>	<u>Total Project Contribution (\$000)</u>
GOT	\$ 837.2
USAID	1,188.3
FPIA	544.5
UNFPA	50.0
	<hr/>
	\$ 2,620.0

The financial participation of the GOT amounts to a total of \$837,200 (205,114,000 CFA) which comprises 31 percent of the total project costs. The only item which would appear for the GOT in 1977 is the expenditure for land which is presumably an internal government transfer payment. The Togolese Ministry of Health budget as well as the general budget from 1972 to 1976 are shown in the following table:

Health Budget and National Budget
TOGO
(in CFA 1,000,000)

<u>Year</u>	<u>National Budget</u>	<u>Health Budget</u>	<u>Health as % of Nat.</u>	<u>Health Personnel Budget</u>	<u>Health Material Budget</u>
1972	12,283	798	6.5	625	173
1973	13,484	880	6.6	685	195
1974	16,245	943	5.8	738	205
1975	30,515	1,252	4.1	960	292
1976	50,019	1,584	3.2	1,185	399

Source: Rapport D'Activites des Services de Sante
1967 - 1976 Pg. 4,5

Future national budget projections are based on the following assumptions. Togo's foreign exchange rose from \$39.7 million in September 1976 to \$58.7 million in January 1977, while international reserves over the same time period from \$47.9 million to \$66.8 million. Phosphate production, the main export earner, rose from 1.1 million tons in 1975, to about 2 million in 1976 and is projected to reach 3 million tons in 1977. While phosphate prices may not remain at their present high level, there is unlikely to be any precipitous decline. The next highest export earners are coffee and cocoa. The World Bank, FAC and Togolese financing are all being used for replacement of 30 to 45 year old plantations. With a replacement schedule involving over 8,000 hectares by 1980, it is hoped that production of 20,000 tons of coffee and 25,000 tons of cocoa can be achieved annually. Togo's new oil refinery to process mainly Nigerian oil has opened recently with a capacity of 1 million tons per year. The expansion of cement production should make Togo self-sufficient in 1977 and produce a small surplus thereafter. This adds up to a steadily monetary economy, with most of the growth in the industrial sector, but gradual improvement in agricultural production. Based on this picture it seems reasonable to assume an annual 10 percent growth in the Togolese National Budget over the period of the project.

The Togolese health budget has been a declining share of the National Budget but the present level of 3.2 percent appears to be as low as political pressures will allow it to drop. Therefore, the assumption was made that the health budget would remain at this level of funding over the life of the project.

The portion of the health budget going to personnel has remained relatively stable at around 75 percent, so this level was used to prepare future projections. Inflation was ignored in the national projections, but was built into the staff salaries at the Center. This would probably result in over-estimating the share that the Center salaries represent of the total health budget of the MOH. As can be seen from the table, during full Center operation, they do not exceed 1.5 percent of total Ministry salaries. Furthermore, most of the senior staff of the Center are already on the Ministry of Health payroll and so do not represent a net increase. The operating costs of the Center likewise would form an insignificant increase to the MOH budget. Several

components of the operating costs of health centers and hospitals such as electricity, water and telephone service charges do not appear on the health budget, but are charged against a general government services item in the Togolese National Budget. When FPIA phases out its assistance, the MOH will have to assume some additional costs for such items as contraceptive supplies. These are not large enough to pose a problem. In conclusion, recurrent costs added to the MOH by the construction of the Center seem low and well within the capacity of the GOT and MOH to assume upon phase-out of foreign assistance.

Projections of Togolese National and Health Budgets

(in CFA 1,000,000)

<u>Year</u>	<u>National Budget</u>	<u>Health Budget</u>	<u>Health as % of National</u>	<u>Health Personnel Budget (75% of Budget)</u>	<u>Staff Salaries as a % of Total Health Personnel</u>
1977	55,021	1,761	3.2	1,321	
1978	60,523	1,937	3.2	1,453	
1979	66,130	2,130	3.2	1,597	0.4
1980	73,232	2,343	3.2	1,757	1.0
1981	80,555	2,578	3.2	1,933	1.4
1982	88,610	2,836	3.2	2,127	1.4
1983	97,471	3,190	3.2	2,395	1.4

TABLE III SUMMARY COST ESTIMATE AND FINANCIAL PLAN
PROJECT PAPER

(US\$000)

SOURCE	AID		TOTAL AID	HOST COUNTRY		FPLA		TOTAL
	FX	LC		FX	LC	FX	LC	
Design and Construction of Center	839		839		25			864
Personnel	180	20	200		459	174	26	832
Furniture & Equipment	139	10	149			260*		409
Training					110		70	172
Research Funds							50	50
Operating Cost (medicines, pharm., maint. utilities)					243		15	230
GRAND TOTAL**	1158	30	1188		837	434	161	2620

*Includes \$50 for anticipated UNFPA input

**Costs include contingency and inflation. They are itemized and explained in Annex C1.

TABLE IV. COSTING OF PROJECT OUTPUTS/INPUTS

PROJECT PAPER

NEW

REV # 1

PROJECT # 693-0212

TITLE TOGO FAMILY HEALTH

PROJECT INPUTS	PROJECT OUTPUTS					TOTAL
	#1 Trainees	#2 Parts.	#3 Constr.	#4 Cur.Dev.	#5 Ed. Mat.	
<u>AID</u>						
1. Constr. (A&E, labor material)			839			839
2. Personnel (T.A. & Secretary)	160			40		200
3. Furn. & Equip.			149			149
<u>GOT</u>						
1. Land (Center site)			25			25
2. Personnel (salaries of staff)	383			50	26	459
3. Trng. (per diem & transport)	110					110
4. Operating Cost (utilities, maint., medicines, pharm.)	192			51		243
<u>FPIA</u>						
1. Personnel (short- term T.A. & Sec.)	80			100	20	200
2. Commodities & Equip.	130		80	30	20	260
3. Training		70				70
4. Res. & Eval.	40			5	5	50
5. Operating costs	15					15
TOTAL	1110	70	1093	276	71	2620

C. Summary of Social Analysis (complete text attached as Annex L)

Attitudes Toward Family Planning

A pilot socio-demographic survey of the predominantly Ewe Maritime Region, the most populous and densely populated region in Togo, was carried out in 1969 by the Department of Sociology, University of Ghana. A total of 293 females, 15 years and over were interviewed. This survey was repeated later in all regions of Togo and the findings were very similar to those of the Maritime Region. The following paragraphs recapitulate some of the findings of the initial pilot survey.

The results of this survey have shown that very little or no family planning is practiced in Togo. However, the majority of women interviewed were clearly aware of the adverse effects of too many children at too short intervals not only on themselves but on their children. They see such effects mainly in terms of health hazards to the mother and health and nutritional hazards to the children. They also recognize adverse economic effects. The study clearly shows that the women are becoming increasingly aware of the associated economic burdens of a large number of children under current conditions of high cost of living.

The women interviewed may have a large number of children at too short intervals. However, their answers show that if they had their own way, the bulk of them would have their children well spaced out around 3-year intervals. If they do not at present achieve this, it does not mean they do not know the implications of having many children too close together but rather that they do not know HOW or do not have the MEANS to achieve this without much physical, psychological, emotional and matrimonial hardship to themselves. At present, most of them attempt to do this by imposing sexual restrictions on themselves by moving away from their husbands. But this seems to be highly unnecessary given the advanced state of contraceptive technology today. They should be able to achieve the same ends without unnecessary and costly hardships. The most important factor, however, is that they are aware of the need to space their children. Their only problem is the lack of knowledge of modern methods to regulate births.

The results of this survey throw doubts on many ideas and views held about attitudes of the rural women to family planning. These findings show that rural women are not as conservative as they are usually pictured; that the basic problem is lack of knowledge of the means, possibilities, potentials and medical as well as health soundness of hazards of family planning methods and techniques. The rural woman is willing to have access to family planning techniques and may be willing to adopt these wholeheartedly provided she is approached in the right manner.

Spread Effects. The Diffusion of Innovation

The actual target groups of this project are limited to women in the reproductive ages of 15-44 years and children 0-5 years of age. With an estimated population in Togo of 2.2 million in mid-year 1977, there are about 525,000 women (21 percent of the population) in that age group and an equal number of children under five years of age. These two groups - representing 42 percent of the population - will be the primary beneficiaries of the project. They will receive the bulk of family health services: pre-natal and post-natal care, family planning services, nutrition education and control of nutritional status, immunizations against communicable diseases and pediatric consultations. Indirectly, however, the whole family will benefit from improved family health.

The school age children will receive sex education in the schools. The husband will benefit both socially and economically from the child spacing services provided for his wife (or for himself, if he chooses to use condoms). It should be noted however, that generally clinical services will not be offered to males at the Family Health Center. They will be treated at existing facilities. Better sanitation, control of communicable diseases, will benefit all members of the family. Thus the nation as a whole should ultimately, directly or indirectly, benefit from the training programs and health educational services provided for by this project.

As described in the Technical Analysis, the spread effect of the project depends on the actual performance of the students at the Center when they return to their posts. With approximately 120 trainees returning each year after having received in-depth training in family health and a conservative estimate of each of the returned trainees consulting or treating 10-15 patients per working day, the combined effects of the project would mean some

400-500,000 family health consultations or services provided by first-year trainees. This number will double the next year and triple the third year.

However, the total number of consultations or services provided gives only a rough idea of the benefits expected from the project. The percentage of women and children who will ultimately benefit from improved family health services is more important. As noted in the revised Health Sector Assessment, page 25: 70 percent of the rural population live within a distance of 10 km. (about 6 miles) from the nearest health facility; 75 percent of the women prefer professional health personnel to assist at their deliveries; and more than 90 percent of the mothers interviewed at the survey would seek medical care for their children when they were sick. These figures are strong indicators that the great majority of the target groups will benefit directly from improved maternal and child health services.

While the above may indicate the possible spread effect of the project, the question about "the diffusion of innovation" has not been fully answered. The introduction of family planning as a means of child spacing is one of the most important innovations of the project. There are several factors determining acceptance of family planning services. Foremost among these are: (1) easy access to services; (2) the quality of the services provided; and (3) the motivation of the population to accept family planning.

As stated earlier, family planning services will be immediately available in at least one MCH Center in each health district. However, as the number of trained personnel and of health Centers providing family planning services increases each year there should be easy access to family planning services for about 70 percent of the rural population within the next six years. The quality of services is important because the satisfied acceptor of family planning is the best motivator of her neighbor. The word spreads quickly in rural Togo. A few clumsily done IUD insertions or a few unexpected complications from "the pill" can easily spoil or delay a family planning program for years. As mentioned earlier, the motivation for child spacing is extremely high among the rural women in Togo. With well organized mass educational programs, training auxiliary midwives, social agents/animateurs and agents itinerants to further educate and motivate people to accept family planning, the

basis for an extensive family planning program will exist in Togo. Nevertheless, experience has shown that acceptance of family planning by an illiterate, poor rural population takes time. Therefore, a reasonable - but still rather ambitious - target would be that ten percent of married couples - or approximately 40-50,000 women or couples will utilize a modern contraceptive method within the next five years of full operation of the Center (i.e., FY 1985).

D. Economic Analysis

Togo is faced with many problems characteristic of developing countries. Attempts to achieve a rising level of per capita income are usually accompanied by changes in the consumption, production, trade and other aggregates. The development of the Togo Family Health Center is expected to improve the health and social welfare of a major segment of the population, but due to the interlocking relationships between various aspects of the development process it could affect other structural characteristics.

The demographic characteristics of Togo are similar to those of neighboring countries. The present population is about 2.2 million with a crude birth rate of about 55 and death rate of 29 per thousand. The annual population growth rate is 2.6. Over the past decade, the birth rate has been reasonably stable, while the death rate has been declining slightly. This has resulted in a slight increase in the life expectancy, currently about 40 years.

After five years of full operation, the family health program will affect primarily two population groups and changes in the demographic characteristics of these groups can be expected to alter certain economic variables. For women in the child-bearing years, the likelihood exists that the following changes will occur: a) a decline in maternal mortality; b) a reduction in the age-specific birth rates for the youngest age groups (10-14 and 14-19); and c) an increasing birth interval between children. For babies and infants, the following changes may occur: a) a light reduction in the crude birth rate; and b) increasing survival rates in the 0-1 age group and 1-4, resulting in a slight narrowing of the base of the population pyramid. All of these changes, even if minor, have economic implications. The knowledge and ability necessary to defer the timing of the first birth may enable more

secondary school pupils to complete their education and become more economically productive members of the community. Increased survival of infants may reduce foodstuff consumption and assure better nutritional and mental growth for infants in smaller families.

The inclusion of some demographic studies in the research funding will enable some specification of population variation and change. The inclusion or linking of social and economic variables to population studies will give some data on which future funding of this type of center can be evaluated. Insufficient information is available to evaluate the expected impact of improved maternal and infant health upon demographic variables, and through these to economic variables.

All sectors of Togo's government can be regarded as competing for scarce resources. It would be impossible to evaluate the benefits accruing from this specific project contrasted or compared with a similar expenditure on, for instance, an agricultural project. However, it would appear that in the long run if the project ever resulted in stabilization of the growth rate, a positive impact on per capita incomes would result. Almost all health interventions in the MCH area result in reduced death rates and without improved child-spacing techniques, growth rates have to rise. This stresses the already difficult balance between population growth and economic development indices.

A major concern in the establishment of the Togo Family Health Center is whether it constitutes the best utilization of the health dollar. The health budget as a percent of the general operation and investment budget was about 3 percent in 1976. However, it should be recognized that this is an incomplete tabulation, excluding all the expenses associated with the medical school in Lome, and also omitting the private health sector. The MOH health budget on a per capita basis amounted to about \$2.90 in 1976.

The health sector in Togo is oriented towards curative medicine, perhaps as much as 75 percent of the budget being curatively oriented. This project represents a preventive approach. It is generally agreed that the only way in which people can improve their environment and health habits is through a preventive medical approach. The Family Health Center will attempt to reorient the work of the paramedical personnel of the country towards a preventive approach. This is generally a lower cost

method of tackling the problems resulting from poor sanitary practices, lack of nutrition education and infectious diseases than taking a curative approach after people have become ill.

It can be ascertained that the numbers and types of personnel receiving training are quite large. The cost per student receiving either in-service training or covering a portion of the curriculum in the Center will be quite low. However, the cost of giving all the senior level MOH personnel in-service training anywhere else in Francophone West Africa would obviously be much higher. It should be noted that even the mid-level personnel and students receiving primarily classroom instruction will benefit from watching clinical care demonstrations even if their participation is limited.

Health personnel now in the rural areas have received their training in schools and in hospitals oriented towards curative care. This program will ensure retraining of the majority of rural health workers in preventive medicine at a low cost. Since Togo is a small country, travel expenses from even the most northern parts are not high. Per diem rates given by the MOH are very moderate but evidently sufficient to cover expenses.

Retrained workers receive their regular salary when they return to their rural health post. For a modest outlay a high percentage of Togo's rural health workers will have improved old skills and learned new ones. The MOH can thus increase both the efficiency and effectiveness of rural based health personnel in rendering both curative and preventive services to existing MOH personnel, and becoming part of the existing curricula of the training schools for medical personnel.

Part IV. Implementing Planning

A. Administrative Arrangements

1. GOT

With the exceptions of distribution of educational materials and the administration of procurement for the design and construction of the Center, GOT administration of this project will be entirely within the Ministry of Health, Social Affairs and the Advancement of Women (MOH). The entity charged with direct responsibility is the

Division of Mother and Child Hygiene (MCH). This division will coordinate the development and production of sex education materials with the Division of Sanitation and Health. The Ministry of Education is responsible for the distribution of sex education materials for use in primary and secondary schools. Public Works (Ministry of Equipment) will be charged with the procurement of design and construction services for the Center.

The organizational chart of the MOH (attached as Annex F) shows the organization of the MOH at the central level. The structure is strongly hierarchial and administration is highly centralized with a vertical line of command. This structure makes coordination between divisions difficult and inhibits information-sharing between division heads on related programs outside the MOH.

Policy decisions and health planning are made at the ministerial level with advice and consent of the Cabinet and the Permanent Health Planning Unit. Major decisions are made by the Director General of Health. In the event of his absence, decision making is often postponed.

The Director General is responsible for the operation of all health services and coordination of all foreign donor inputs. All senior positions in the Ministry are held by well qualified people and all division chiefs report to the Director General or his Deputy. There are eight divisions, as follows:

The Division of Mother and Child Hygiene (MCH) is responsible for all MCH services including nutrition and family planning. It supervises all MCH Centers, provides training in MCH and family planning of health personnel, and has produced an excellent illustrated book on Family Health in Africa for trainers. This division will be responsible for the proposed Family Health Training Center in Lome. The Center Director will be charged with day-to-day management and other responsibilities listed under Section IV A2 for the U.S. financed health advisor/administrator.

The Division of Sanitation and Health Education is responsible for sanitary facilities, for setting sanitation standards, control and legislation concerning potable water supplies, refuse disposal, etc. The section of health education is responsible for health promotion, production of health education materials, training of health personnel in

health education, etc. The chief of the section is also secretary-general of a newly created association of African health educators, which promotes health education in Africa through international conferences, etc. The health education chief has been one of the leading promoters of integrating family planning with maternal child health services. He presented this concept at a conference in Atakpame, February 1977, attended by some 25 health educators from Francophone West Africa. The Health Education Division has also sponsored several radio and TV broadcasts on family health and sex education, including family planning.

The Division of Administration is responsible for budget/financing, transportation and personnel.

The Division of Epidemiology is responsible for epidemiological surveillance, control of communicable diseases, health statistics and tuberculosis control. The "Grandes Endemies" has five mobile units which cover the whole country with mass immunization programs: mainly smallpox, yellow fever, measles and BCG vaccinations against tuberculosis. DPT (diphtheria, pertussis and tetanus) immunization of children and tetanus toxoid immunization of pregnant women are provided in all larger maternal and child health (MCH) Centers. Because of lack of refrigeration for storage of vaccines, most rural dispensaries do not provide this service, but rely on visits by the mobile units from the "Grandes Endemies". The section of health statistics relies on the National Computer Center which serves all governmental needs. Because of difficulties with the computer the annual reports on "Statistiques Sanitaires" have been delayed for years. The GOT has now installed a new and larger IBM computer and the statistics section is catching up with its backlog.

The Division of Medical Assistance and Basic Health Services has the responsibility for all hospitals, health centers and dispensaries, and for the training of the itinerant auxiliary health personnel in the pilot zone of Vogon.

The Division of Pharmacies is responsible for pharmaceutical supplies, inspection of pharmacies, and control of drug addiction.

The Division of Training is responsible for the training of public health personnel.

The Division of Laboratories is responsible

for the National Institute of Hygiene and for regional and sub-division public health laboratories.

The responsibility for the major decisions for the Family Health Center will rest with the Director of the Division of Mother and Child Hygiene (MCH), a well-qualified Togolese physician. The Director has the strong support of the Director General of Health who delegates to the Divisional Director all daily decisions affecting maternal and infant care. Lateral links with other Divisions in the Ministry are less well developed, and decisions affecting two or more Divisions involve more cumbersome paper work and lengthy meetings. Thus decisions on the equipping, staffing and annual allocation for the pharmacy and laboratory in the Health Center will probably be time consuming, even though a satisfactory outcome can be expected.

Staffing in all Divisions with which the Family Health Center has an interface is almost entirely with Togolese. Togolese physicians have all been trained abroad since the Medical School has only recently been established. They are well trained, and sufficient specialists already exist in the relevant areas, obstetrics and gynecology, pediatrics and general practice to staff the Center and provide back-up services. Midwives and senior nurses are available and trained, some having already additional training in family planning in Canada and the United States to form the core staff for the Center. No difficulty is anticipated in filling lower level positions since sufficient personnel exist in all categories.

Annex C4 gives a complete breakdown of medical personnel in the MOH. Recruitment for the senior staff, many of whom are already on the Ministry payroll is unlikely to be a problem since Lome is the preferred work location.

Travaux Publics

Although somewhat outdated, the organizational chart attached as Annex G provides an illustration of the organization of Travaux Publics (TP). TP is comprised of two kinds of units: (1) the technical general services and joint technical services divisions which constitute the Direction; and (2) the implementation units or subdivisions. The Director coordinates and controls all the activities of The Direction and is assisted by his deputy director.

TP has a staff of two architects and approximately 25 engineers specialized in various fields including

buildings, roads, bridges, hydraulics and energy. They are supported by approximately 1500 lower level technicians and a general administration staff of approximately 300 people.

There are four technical divisions within the Direction headed by a Division Chief of TP. The divisions are: (1) Roads, Bridges and Airports; (2) Hydraulics and Energy; (3) Buildings; and (4) Architecture and Urbanism. They are responsible for planning and implementation of projects as well as the administration of projects which are contracted out to private firms.

Over the last five years TP has designed and supervised construction of several complex buildings including the Sokode Hospital, Hotel de la Plage and the luxurious Hotel de la Paix. These tasks called for considerably more expertise than required for the modest health facility to be constructed in this project.

TP will be charged with the procurement of design and construction services and supervision of the construction for the Family Health Center. This will include preparation of request for technical proposal, synopsis for bid, bidder prequalification, issuance of bid invitations, selection of bidder and negotiation and execution of contracts acceptable to AID. With AID support as described following in the sub-section, TP is well qualified to carry out these tasks.

As practically all responsibilities for the project are within the MOH, the coordination of the inputs should not pose any particular problem. However, to assure coordination of all project activities and their timely implementation, a representative from TP will be added to the existing Inter-Ministerial council, composed of the representatives from the divisions within the MOH, the Ministry of Education and Association Pour le Bien-etre Familiale. They will meet as requested by the Center Director.

2. AID

REDSO/WA will also supply an engineer to monitor supervision of construction. This engineer will visit the site periodically and will work closely with the supervisory personnel of Travaux Publics.

The AID-financed public health advisor/administrator will play a key role in implementation of project activities. He will be directly responsible for providing on-the-job training to his Togolese counterpart, the Center Director. In collaboration with the Center Director, he will assist with the coordination of major inputs, i.e. goods and services and the monitoring of day-to-day activities. More specifically, he will assist the Center Director in the many management or administrative and logistic aspects of the training programs conducted at the Center and the follow-up of trainees who have returned to post. While the FPIA consultants to the project will be fully responsible for curricula development and other technical aspects of the training program, this U.S. project technician will assist in developing and revising curricula and coordinate other efforts with FPIA consultants. He will submit semi-annual progress reports to AID/Lome which will reflect all technical as well as financial aspects of the project.

A two year host country contract with the MOH will be used for the procurement of the U.S. technician's services. However, recruitment of this technician will be carried out by AID/W simply because the GOT does not have the facility to do so. He will be responsible to the MOH and only in turn to U.S. AID/Lome. As directed by U.S. AID/Lome, this technician will identify possibilities and needs for further U.S. support to the Togolese rural health delivery system as recommended in the revised Health Sector Assessment and eventually do the preparatory planning for such support. The U.S. technician's services will start mid-FY 79. With that mandate the requirements for the position as Public Health Advisor will be: a Master of Public Health (MPH) degree or equivalent, with major in public health administration and/or health education; experience in LDCs, preferably in Africa, in clinical and out-patient management or management of health training institutions; and fluency in French.

3. F.P.I.A.

FPIA is well known to AID. It will be responsible for the entire training component of the project. The experience that FPIA brings to this project is likely to be a very promising factor in its successful implementation. This organization in collaboration with the Ethiopian Family Planning Association established a "Health and Welfare Center" three years ago in Ethiopia. The purpose of the

Ethiopian Center was similar to that of this project: to bring improved MCH/FP service to the rural population through training its medical and paramedical personnel in "family health".

According to Mr. L.H. Robinson, the Africa Regional Representative for FPIA, the establishment of a "Health and Family Welfare Center" was a key to the project's credibility and acceptance. As in Togo, a core group of medical and paramedical personnel had already been trained abroad and were employed in MCH/FP and were supported by specialists in OB-GYN, Public Health from the University. "This combination of factors proved highly successful. Within two years over 165 health personnel had been trained in MCH/FP; service delivery points increased from 26 in 1975 to 179 by the end of 1976. Likewise, there was a tenfold increase in family planning acceptors, primarily in rural Ethiopia."

B. Implementation Plan

1. Prior Actions

In order to assure a relatively smooth flow to the implementation of this project, the following actions should be taken before the Project Agreement is signed:

- a) Responsible Party: AID/W

All waivers and approvals requested in Section IV-C need to be obtained;

- b) Responsible Party: REDSO/AID AFFAIRS OFFICER/GOT.

Once the PP is approved and the appropriate approvals and waivers are obtained it will be necessary that the appropriate REDSO personnel visit Lome for the purpose of explaining thoroughly AID procedures required by Handbook 11.

- c) Responsible Party: GOT

Upon approval of the PP, the MOH should contact AAPC with regard to its availability and fee to act as procurement service agent.

A Project Performance Tracking Network providing a schedule from the submission of the PP project approval through completion of AID's implementation role in the project is attached as Annex A

C. Procurement Plan

Responsibility

Procurement of U.S. equipment and commodities will be undertaken by the MOH through its authorized representative. The MOH has indicated that the Afro American Purchasing Center (AAPC) will be designated as its procurement services agent. AAPC will be queried as to its availability and fee.

Local procurement on behalf of the MOH will be made through the MOH's procurement office. Local purchases will be conducted in accordance with good commercial practices

and as far as practicable on a competitive solicitation of offers.

Equipment and Commodities List

According to current projections, the itemized equipment and commodities list attached as Annex C3 will be purchased for project use. Project needs may result in minor shifts from one commodity to another but are not expected to alter the overall purchase costs.

While a maximum effort was put forth to determine furniture and equipment needs for the Center, it is quite probable that some items may not have been included. Therefore to add some flexibility to the purchase of commodities and to avoid any delay in implementation due to lack of a particular piece of equipment, local currency authorization is requested in the amount of \$10,000.

Source and Origin

Pursuant to Handbook 11, Section 3E1a. the authorized source and origin for procurement of equipment and commodities will be limited to the U.S. and Togo.

Design and Construction of Center

Host country contracting will be used for procurement of architect and engineering and construction services of the Center. It is anticipated that the architect and engineering services, which will include the preparation of the IFB plans and specifications, will be procured locally, as total estimated costs for this service is estimated to be less than \$50,000. At least two Togolese architectural firms have been located to date which are fully capable of performing the desired services. Local qualified and eligible firms will be advised of the request for proposals and selection will follow procedures outlined in Chapter 1 of Handbook 11. The architect and engineering contract will be a lump sum type contract for design, and if some supervision of construction is required, payment will be made on a time-rate basis.

Construction will also be procured locally from host country or Code 941 countries, as experience in West Africa has indicated that no U.S. construction firm could prepare a competitive cost proposal for a project of this

magnitude. It is not intended that the project be advertised in the U.S. through the Commerce Business Daily or the Small Business Circular. Local or Code 941 firms desiring to participate in the bidding procedure will be required to submit prequalification data. Prequalified firms will then be invited to submit bids. Award will be made to the responsive prequalified bidder submitting the lowest price proposal. Payment will be made on a unit price basis for construction.

All materials to be used in the construction of the Center can be provided from host country sources, either on the basis of origin in the host country, authorized shelf item procurement of commodities which are transformed locally from raw materials imported from AID Geographic Code 935 countries.

Source and Origin

Pursuant to Handbook 11, Sections 1D1a and 2D1a, the authorized source and origin for architect and engineering and construction services of the Center is limited to the United States and Togo.

Waivers

A procurement source waiver of construction services from AID Geographic Code 000 to AID Geographic Code 941 plus the cooperating country is requested.

Justification

As stated above, no U.S. construction firm could prepare a competitive cost proposal for a project of this magnitude as there are no U.S. owned or controlled construction firms in Togo. Therefore, to introduce an added element of competition, it is necessary to permit 941 firms to compete for construction services.

D. Evaluation Plan

During the life of the project three routine evaluations and one depth evaluation are planned. One year from the signing of the Project Agreement, the Center Director will prepare and submit a Project Evaluation Summary (PES). At the end of years two and three project evaluation summaries will be prepared by

the AID-financed technician in collaboration with the Center Director. These PESs will include a summary of progress to date, preliminary prospects of achieving the project purpose and major problems or changes which have an impact on the project. The PESs will also be supplemented by semi-annual progress reports submitted initially by the Center Director and later in collaboration with the U.S. technician.

Periodic self-evaluation and trainee assessments will also be carried out during the life of the project. Trainees' skills and knowledge will be measured before and after each training cycle by the Center staff, particularly the FPIA research/evaluator and his Togolese counterpart. Contingent upon the overall knowledge of a group of trainees, the content of the courses will be adjusted to allow for additional inputs and/or deletions. Likewise content can be adjusted at the end of each training cycle to accommodate changes recommended by the Center staff and trainees. Trainees will also assess the training program before graduation, thus providing a valuable source of feedback and resulting in a finely-tuned program.

A depth evaluation will be undertaken at the end of FY 1981. This evaluation will be carried out by an AID/W representative, the REDSO/WA Health Officer, an FPIA representative and a representative of the MOH.

The logical framework will provide the basis for this evaluation. The means of verification provided in the logical framework should provide sufficient information upon which to base this depth evaluation. Under the supervision of the Center Director and the FPIA evaluator/researcher, the trainees will collect project baseline data by carrying out small knowledge of attitudes to and practice of family planning (KAP) studies and sample surveys of socio-demographic and epidemiological data in the Bè district of Lomé. As stated in the project description, project benefits will accrue initially to the population in this area. This depth evaluation will provide the guidelines for a continuation of AID activities in the health sector.

Service statistics such as the number of people trained, where they return to, number of pre- and post-natal examinations consultations, immunizations, number of family planning acceptors, etc., will be compiled by the staff at the Family Health Center and other MCH and health centers from which trainees are selected during the life of the project. In addition, sample socio-demographic and epidemiological surveys will be carried out in selected rural areas chosen by the Center staff. These surveys will be carried out by trainees supervised by Center staff

members, the FPIA research/evaluator, and the U.S. technician and will provide baseline data upon which to evaluate the spread effect of the project. Ideally, this should be an ex-post facto evaluation carried out by AID/W five years after the Family Health Center has been fully operational, i.e. FY 1985.

E. Conditions, Covenants and Negotiating Status

Conditions Precedent to Disbursement

The GOT will furnish to AID an executed contract for architectural design of the Center acceptable to AID with a firm acceptable to AID.

Additional Disbursement

1. The GOT will furnish to AID suitable procurement arrangements for commodities.

2. The GOT will furnish to AID plans and specifications, bid documents, cost estimates and time schedules for carrying out the Project.

3. The GOT will furnish to AID an executed contract for construction of the Center acceptable to AID with a firm acceptable to AID.

The Project Agreement should contain the following covenant.

During the implementation of the project and at one or more points thereafter, GOT and AID will: (a) evaluate progress toward the attainment of the objectives of this project; (b) identify and evaluate problem areas or constraints which may inhibit such attainment; (c) assess how such information may be used to help overcome such problems; and (d) evaluate to the degree feasible to overall development impact of the project.

Negotiating Status

The FPIA contribution is subject to FPIA/New York and AID/W approval. It is anticipated that final AID/W approval will be obtained the latter part of September 1977, and that FPIA and the GOT will sign an agreement early October, 1977.

The UNFPA contribution of \$50,000 for three vehicles, mopyettes and bicycles is still under consideration.

Subject to approval of this PP, negotiation of the Project Agreement will take place during the month of

-61-

September. The suggested covenant and conditions precedent will be negotiated at that time. The target date for signing of the Project Agreement is September 29, 1977.

COUNTRY	PROJECT NO.	PROJECT TITLE	DATE	<input type="checkbox"/> ORIGINAL <input checked="" type="checkbox"/> REVISION # 1	APPROVED
TOGO	693-0212	TOGO FAMILY HEALTH	8/12/77		
PROJECT PURPOSE (FROM PRP FACESHEET)					
To strengthen the GOT's institutional capacity to provide improved family health services to its populace, particularly pregnant and lactating mothers and children 0-5 years of age in rural areas through in-depth training of medical paramedical and social personnel in various aspects of family health.			12.	12/30/77	- Evaluate & Select Consultant GOT
			13.	1/14/78	- AID approval consultant REDSO
			14.	1/30/78	- Advertise prequalification GOT
			15.	2/15/78	- Design contract negotiated GOT/Cons.
			16.	3/1/78	- AID approval design contract REDSO
			17.	3/3/78	- Procurement agent approved AID/W
			18.	3/15/78	- Receive prequalification (Constr.) GOT
			19.	3/6/78	- Design starts (includes IFB plans & specs) Consult.
			20.	4/30/78	- Firms prequalified & short listed GOT
			21.	5/30/78	- Short list approved REDSO
			22.	6/6/78	- Design/IFB completed Consult.
			23.	7/1/78	- FH Center staff selected GOT
			24.	7/6/78	- AID approval design/IFB REDSO
			25.	7/10/78	- Equipment list refined GOT/AAPC
			26.	7/14/78	- 1st group participants selected GOT
CPI DESCRIPTION					
1.	8/16/77	- PP submitted to AID/W ADO/Niamey			
2.	8/17/77	- FPIA proposal submitted to FPIA/N.Y. FPIA/AFR			
3.	9/9/77	- PP reviewed/approved (includes waivers). AID/W			
4.	9/9/77	- FPIA proposal approved. FPIA/NY			
5.	9/12/77	- Preparation/negotiation ProAg ADO/Niamey/GOT			
5.	9/14/77	- FPIA proposal submitted AID/W FPIA/NY			
7.	9/29/77	- FPIA proposal approved AID/W			
8.	*9/29/77	- Pro-Ag signed ADO/Niamey/GOT			
		*Target date			
9.	10/31/77	- RFP prepared GOT/REDSO			
10.	11/15/77	- RFP approved REDSO			
11.	11/30/77	- Informal solicitation GOT			

COUNTRY	PROJECT NO.	PROJECT TITLE	DATE	<input type="checkbox"/> ORIGINAL <input checked="" type="checkbox"/> REVISION # <u>1</u>	APPROVED
TOGO	693-0212	TOGO FAMILY HEALTH	8/12/77		
PROJECT PURPOSE (FROM PRP FACESHEET)			30. 11/18/78 - Evaluate & award		GOT
CPI DESCRIPTION (26 cont'd)			31. 11/30/78 - Procurement documents prepared		GOT/AAPC
			32. 12/18/78 - AID approval/award contract		REDSO
a) 5 midwives (AFR)			33. 1/1/79 - 1st grp. partic. complete trng.		GOT/FPIA
b) 1 physician (AFR)			34. 1/9/79 - 2nd grp. participants start training		GOT/FPIA
c) 1 health educator (AFR)			35. 1/15/79 - Equipment ordered		GOT/AAPC
d) 1 social agent (AFR)			36. 1/20/79 - Contractor mobilized		Contractor
27. 8/16/78 - Firms secure IFB		GOT/Contr.	37. 1/21/79 - Construction starts		Contractor
28. 9/1/78 - 1st group parts. start training		GOT/FPIA	38. 3/5/79 - In-service refresher course for Center staff		FPIA/GOT
A. 9/9/78 - US technician recruited		AID	39. 4/9/79 - US technician arrives		AID/GOT
B. 9/18/78 - Equip. specs completed		GOT/AAPC	40. 5/9/79 - 2nd group partic. complete trng. (US & AFR)		GOT/FPIA
C. 9/29/78 - Proj. Eval. summary		GOT	41. 6/9/79 - Identify 1st grp. trainees		GOT
D. 10/6/78 - GOT receive constr. tenders		GOT/Contr.	42. 8/9/79 - Identify 2nd grp trnees.		GOT
29. 11/10/78- 2nd grp partic. selected		GOT	43. 9/29/79 - Project eval. summary		AID/GOT
a) same as 1st (a) and (d)			44. 10/5/79 - Identify 3rd grp trnees.		GOT
b) Center Director (US)			45. 10/9/79 - Initial curriculum & ed. material developed		FPIA/GOT
c) Researcher/evaluator (US)					

COUNTRY	PROJECT NO.	PROJECT TITLE	DATE	<input type="checkbox"/> ORIGINAL <input checked="" type="checkbox"/> REVISION # <u>1</u>	APPROVED
TOGO	693-0212	TOGO FAMILY HEALTH	8/12/77		
PROJECT PURPOSE (FROM PRP FACESHEET)					
CPI DESCRIPTION					
46. 10/15/79 - Equipment arrives	GOT/AAPC		57. 4/7/80 - Socio-demo & epidemiological survey (Be district)		GOT/FPIA
47. 10/21/79 - Construction completed	CONTRACTOR		58. 4/15/80 - Curriculum revised		FPIA/GOT
48. 11/1/79 - AID approval constr.	REDSO		59. 4/19/80 - Identify 6th grp trainees		GOT
49. 11/10/79 - 3rd grp. parts. selected (same as above)	GOT		60. 5/3/80 - 3rd trng. cycle starts (30 days)		FPIA/GOT
50. 12/9/79 - Identify 4th grp trainees	GOT		61. 5/9/80 - 3rd grp. parts. complete training		GOT/FPIA
51. 12/21/79 - Center equipped and staffed	GOT		62. 6/3/80 - Follow-up of trainees		GOT
52. 1/3/80 - 1st training cycle starts (30 days)	GOT/FPIA		63. 6/19/80 - Identify 7th grp trnees.		GOT
53. 1/9/80 - 3rd grp. partic. start training	GOT/FPIA		64. 7/3/80 - 4th training cycle starts (30 days)		FPIA/GOT
54. 2/15/80 - Curriculum revised	FPIA/GOT		65. 8/3/80 - Follow-up of trainees		GOT
55. 2/19/80 - Identify 5th grp trainees	GOT		66. 8/15/80 - Curriculum revised		FPIA/GOT
56. 3/3/80 - 2nd trng. cycle starts (30 days)	FPIA/GOT		67. 9/3/80 - 5th trng. cycle starts		FPIA/GOT
			68. 9/29/80 - Proj. Evaluation summary		AID/GOT
			69. 10/7/80 - Socio-demo/Epid. survey		FPIA/GOT
			70. 10/9/80 - Follow-up of trainees		GOT
			71. 10/15/80 - Identify 8th grp trainees		GOT
			72. 11/3/80 - 6th trng. cycle starts		GOT/FPIA
			73. 11/9/80 - 4th grp parts. selected (5 midwives)		GOT/FPIA

COUNTRY	PROJECT NO.	PROJECT TITLE	DATE	<input type="checkbox"/> ORIGINAL <input checked="" type="checkbox"/> REVISION # <u>1</u>	APPROVED
TOGO	693-0212	TOGO FAMILY HEALTH	8/12/77		
PROJECT PURPOSE (FROM PRP FACESHEET)					
CPI DESCRIPTION					
74. 12/3/80 - Identify 9th grp. trns.	GOT	88. 6/15/81 - Curriculum revised	FPIA/GOT		
75. 12/10/80- Follow-up of trainees	GOT	89. 6/30/81 - Proj. Asst. Completion date	AID/GOT		
76. 1/3/81 - 7th trng. cycle starts	GOT/FPIA	90. 7/3/81 - 10th trng. cycle starts	GOT		
77. 1/9/81 - 4th grp parts. start training	GOT/FPIA	91. 8/9/81 - Follow-up trainees	GOT		
78. 2/3/81 - Identify 10th grp trns.	GOT	92. 9/29/81 - Depth evaluation	REDSO/FPIA/ GOT/AID/W		
79. 2/9/81 - Follow-up of trainees	GOT	93. This project will be completed at the end of FY 83. Although the number of trainees per training cycle will decrease after FY 83, there will be a continuous flow of students from the Togo University Hospital Center and the paramedical schools. Follow-up of trainees and revision of curricula will continue as determined necessary by the Center staff.			
80. 2/15/81 - Curriculum revised	FPIA/GOT				
81. 3/3/81 - 8th trng. cycle starts	GOT/FPIA				
82. 4/6/81 - Identify 11th grp trns.	GOT				
83. 4/10/81 - Follow-up of trainees	GOT				
84. 5/3/81 - 9th trng. cycle starts	GOT				
85. 5/9/81 - 4th grp parts. complete training	GOT/FPIA				
86. 6/3/81 - Identify 12th grp trns.	GOT				
87. 6/9/81 - Socio-demo/Epidem survey	FPIA/GOT				

COUNTRY TOGO	PROJECT NO. 693-0212	PROJECT TITLE TOGO FAMILY HEALTH	DATE 8/12/77	<input type="checkbox"/> ORIGINAL <input type="checkbox"/> REVISION #	APPROVED
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OR FY
CY

FY78

MONTH							AUG	SEPT	OCT	NOV	DEC
PRIOR ACTIONS							(2)	(4) (6) (7)			
							(1)	(3)			
								(5)	(9)	(10) (11)	(12)
								(8)			
ANALYSIS SCHEDULE											
PROGRESS VS FINANCIAL											
EVALUATION SCHEDULE											

COUNTRY TOGO	PROJECT NO. 693-0212	PROJECT TITLE TOGO FAMILY HEALTH	DATE 8/12/77	<input type="checkbox"/> ORIGINAL <input type="checkbox"/> REVISION # _____	APPROVED
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OR FY78
CY

FY79

MONTH	JAN	FEB	MAR	APR	MAY	JUN	JULY	AUG	SEPT	OCT	NOV	DEC
	13	15	16	19		22	24	27		28D	30	32
	14		18	20	21							
			17				25		28B		31	
							23		28A			
							26		28		29	
ANALYSIS SCHEDULE: PROGRESS VS FINANCIAL												
EVALUATION SCHEDULE												

COUNTRY TOGO	PROJECT NO. 693-0212	PROJECT TITLE TOGO FAMILY HEALTH	DATE 8/12/77	<input type="checkbox"/> ORIGINAL <input type="checkbox"/> REVISION # _____	APPROVED
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OR FY80 _____ FY81 _____
CY

MONTH	JAN	FEB	MAR	APR	MAY	JUN	JUL	AVG	SEPT	OCT	NOV	DEC
	52	54 55	56	57 58 59	60	62 63	64	65 66	67	69 70 71	72 73	74 75
	53				61							
ANALYSIS SCHEDULE: PROGRESS VS FINANCIAL												
EVALUATION SCHEDULE												

X

COUNTRY TOGO	PROJECT NO. 693-0212	PROJECT TITLE TOGO FAMILY HEALTH	DATE 8/12/77	<input type="checkbox"/> ORIGINAL REVISION #	APPROVED
OR FY 81 CY			FY 82		

MONTH	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEP7	OCT	NOV	DEC
	76 77	78 79 80	81	82 83	84 85	86 87 88 89	90	91	92 93			
ANALYSIS SCHEDULE:												
PROGRESS VS FINANCIAL												
EVALUATION SCHEDULE												

AID 1020-16 (G 70)

CRITICAL PERFORMANCE INDICATOR (CPI) NETWORK

AID 1020-20 (7-71)
SUPPLEMENT 1

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

(INSTRUCTION: THIS IS AN OPTIONAL
FORM WHICH CAN BE USED AS AN AID
TO ORGANIZING DATA FOR THE PAR
REPORT. IT NEED NOT BE RETAINED
OR SUBMITTED.)

Life of Project:
From FY FY 77 to FY FY 84
Total U.S. Funding \$1,188,300
Date Prepared: 8/12/77

Project Title & Number: TOGO FAMILY HEALTH (693-0212)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Program or Sector Goal: The broader objective to which this project contributes:</p> <p>To improve the health of Togolese populace with particular emphasis on pregnant women, lactating mothers and children in the 0-5 age group.</p>	<p>Measures of Goal Achievement:</p> <ol style="list-style-type: none"> 1) Decrease in prenatal and child mortality rates. 2) Decrease in incidence of preventable communicable diseases. 3) Improved nutritional status of mothers and children 0-5 years of age. 4) Increase in acceptance of modern family planning methods for the purpose of better spacing of child births by FY 1985. 	<ol style="list-style-type: none"> 1) Special socio-demographic and epidemiological studies by trainees initially in the Be district and later in rural areas where trainees have returned. 2) MOH records and reports. 3) Post facto evaluation by AID/W in FY 1985. 	<p>Assumptions for achieving goal targets:</p> <ol style="list-style-type: none"> 1) The GOT, particularly the Ministries of Health, Education, Finance and Plan will continue to give support to the policy and strategy of extending family health services to Togolese families throughout the country. 2) The GOT will continue giving support to improving its rural health delivery system including activities in the nutrition field; demographic data collection storage and use; improved access to safe water; the epidemiological surveillance system; and strengthening middle level health personnel in management of health facilities on regional and sub-regional levels. 3) Other factors such as drought and famine, etc. will not upset the expected benefit of improved family health education and services.

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

AID 1020-20 (7-71)
SUPPLEMENT I

Project Title & Number: TOGO FAMILY HEALTH (693-0212)

Life of Project:
From FY FY 77 to FY FY 84
Total U.S. Funding \$1,188,300
Date Prepared: 8/1/77

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Project Purpose:</p> <p>To strengthen the GOT's institutional capacity to provide improved family health services to its populace, particularly pregnant and lactating mothers and children 0-5 years of age in rural areas, through in-depth training of medical, paramedical and social personnel in various aspects of family health.</p>	<p>Conditions that will indicate purpose has been achieved: End of project status.</p> <p>1) The Family Health Center will have been constructed and equipped; be fully staffed with qualified Togolese personnel; and provide quality in-depth training in the various aspects of family health to medical, paramedical and social personnel as well as quality health services to the population in the Bè district of Lomé.</p> <p>2) Introduction of family health services including family planning by well-trained health personnel in at least one MCH or health center in each of the 21 health districts of the country.</p> <p>3) The following MOH personnel will have been trained or retrained: a) 88% of doctors; b) 85% of midwives; c) 95% of auxiliary midwives; d) 100% of medical assistants and e) 50% of social agents/ animateurs.</p> <p>4) Sex education materials provided to all secondary</p>	<p>1) Annual MOH reports.</p> <p>2) Observation and evaluation of performance of trainees at Family Health Center and trainees returned to their posts by FP Center staff.</p> <p>3) Family Health Center reports.</p> <p>4) Depth evaluation by AID, FPIA and GOT in FY 81 and post-facto evaluation by AID in FY 85.</p>	<p>PAGE 2</p> <p>Assumptions for achieving purpose:</p> <p>1) The MOH will provide a qualified staff and other resources necessary to carry out all functions of the Center at the appropriate time.</p> <p>2) Trainees will effectively utilize their new skills.</p> <p>3) Trainees will be returned by the MOH to rural health posts in the field.</p> <p>4) Family health concepts will be accepted and utilized by the Togolese populace.</p>

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

AID 1020-28 (7-71)
SUPPLEMENT 1

Project Title & Number: TOGO FAMILY HEALTH (693-1212)

Life of Project:
From FY 77 to FY 84
Total U.S. Funding \$1,188,300
Date Prepared: 8/12/77

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Project Purpose:	<p>Conditions that will indicate purpose has been achieved: End of project status. schools and additional sex education materials to all primary schools.</p> <p>5) 10% of married couples using a modern contraceptive method within five years of full operation of the Center i.e. FY 85.</p>		Assumptions for achieving purpose:

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

AID 1920-28 (7-71)
SUPPLEMENT I

Life of Project: From FY 77 to FY 84
Total U.S. Funding \$1,188,300
Date Prepared: 8/12/77

Project Title & Number: TOGO FAMILY HEALTH (693-0212)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS				MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Outputs:	Magnitude of Outputs:					
1) Trainees (trained and/or retrained)	1980	1981	1982	1983	1) Annual Reports by the Family Health Center	Assumptions for achieving outputs:
A) Sr. Level-1 mo Didactic and Clinical					2) Annual MOH reports.	1) Sufficient numbers of different types of health personnel will be available and released from their current duties for the duration of their training or retraining courses.
Physicians	5	10	10	10	3) Inspection by REDSO Engr.	
Midwives	40	40	50	50	4) Project Evaluation Summaries by Center Director and U.S. Technician.	2) Trainees will be carefully selected in accordance with priorities and criteria established by the MOH.
Nurses and Med. Assistants	35	50	60	60	5) Semiannual progress reports by Center Director and U.S. technician	
TOTAL	80	100	120	120		
B) Mid-level 1-2 wks Didactic and clinical						
Auxiliary midwives	80	80	80	80		
Social Agents	40	40	40	40		
C) Lower level variable didactic only	as needed					
D) Student training						
Medical students & interns	10	20	20	20	3) Center constr. by 1/80	
Midwives	30	30	30	30	4) Curricula for senior middle and lower level MOH personnel and student training fully developed by 10/80.	
Medical assts.(incl nurses)	70	70	70	70	5) Pamphlets, educational materials developed, tested, mass produced and distributed by 12/80.	
Auxiliary midwives	40	40	40	40		
Social agents/Animateurs	20	20	20	20		
2) Participants Trained	18	8	5			
3) Center Constructed						
4) Curriculum developed						
5) Health & sex education materials developed						
Actual number of students, types of training and length of courses to be determined by MOH, FPIA and admin. of the schools involved.						

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

AIC 1020-28 (7-71)
SUPPLEMENT I

Project Title & Number: TOGO FAMILY HEALTH (693-0212)

Life of Project:
From FY 77 to FY 84
Total U.S. Funding \$1,188,300
Date Prepared: 8/12/77

PAGE 4

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Inputs:</p> <p>1) <u>AID</u> A. Construction (A&E labor and materials) B. Personnel (TA & Secretary) C. Commodities and equipment Total AID</p> <p>2) <u>FPIA</u> A. Personnel (short-term TA & secretary) B. Commodities & Equipment C. Participant Training D. Local Cost (Research, sec'y) Total FPIA</p> <p>3) <u>GOT</u> A. Land B. Personnel (salaries) C. Training (per diem & tspt) D. Operating Cost Total GOT</p> <p>GRAND TOTAL</p>	<p>Implementation Target (Type and Quantity)</p> <p>Total \$000 839 by FY 80</p> <p>200 (24PM) by FY 80 149.3 by FY 80 1188.3 by FY 80</p> <p>271 (29 PM) by FY 83</p> <p>210 by FY 83 40.7 (102 PM AFR & US) by FY 83 50 by FY 83 544.5</p> <p>25 459.1 by FY 84 110.1 by FY 84 243 by FY 84 837.2 by FY 84</p> <p>2620 by FY 84</p>	<p>1) Review of AID project documentation, ProAg; TA and construction contracts, PILS etc.</p> <p>2) Review of FPIA documentation</p>	<p>Assumptions for providing inputs:</p> <p>1) Timely agreements between all donors.</p> <p>2) Technically competent French speaking technicians are secured.</p> <p>3) Timely delivery of services and commodities agreed upon.</p>

PROJECT COSTS - ANNEX C-1

\$000

	Sept 77 FY 77	10/77-78 FY 78	10/78-79 FY 79	10/79-80 FY 80	10/80/81 FY 81	FY 82	Total \$
I. AID							
A. <u>Design & Construction</u>							
1) Engineering (design only)	50						50
2) Construction (approx 1420 M ²)	497						497
Inflation (20% 1st yr.)	100						100
(20% 2nd yr)	120						120
Contingencies	72						72
Total construction	(789)						789
(Total design & Construction)	(839)						839
B. Furn. & Equipment	118.4						118.4
10% inflation	11.8						11.8
7% procurement fee	9.1						9.1
Local currency contingency	10						10
TA Public Health advisor	180						180
Secretary (bi-lingual)	20						20
TOTAL AID	1,188.3						1,188.3

-76-

	Sept 77	10/77-78	10/78-79	10/79-80	10/80-81	FY 82	Total \$
	FY 77	FY 78	FY 79	FY 80	FY 81		
II. FPIA							
A. Technical Assistance @ \$6 FM							
1) Research/evaluation			6	12	12	6	36
2) Fam. Health Educ/Curric Dev.			12	18	12		42
3) Educ.Mat.Develop.			12	12	6		30
4) OB-GYN			6	12	6		24
5) Nurse-midwife Specialist			12	18	12		42
6) Honorarium (guest lecturers)				2	2	2	6
Sub-total			<u>48</u>	<u>74</u>	<u>50</u>	<u>8</u>	<u>180</u>
B. Commodities							
1) Contraceptive supplies				10	15	20	45
2) Family Planning Kits @ \$1/kit				20	30	40	90
3) Health & sex educ. material and supplies			25	25			50
4) Med equip (exam rms. & audio-visual)			<u>25</u>				<u>25</u>
Sub-total			<u>50</u>	<u>55</u>	<u>45</u>	<u>60</u>	<u>210</u>

\$000

	Sept 77	10/77-78	10/78-79	10/79-80	10/80-81	FY 82	Total \$
	FY 77	FY 78	FY 79	FY 80	FY 81		

C. Participant Trng.

1) 20 midwives (5/yr @ \$4/mo for 3 mos in Afr. \$.7/persons for RT int'l trav.)		9.5 (15pm)	9.5	9.5	9.5		38
2) 3 physicians (1 yr. @ \$.4/mo for 4 mos. in Afr & 7 persons for R.T. int'l tspt.)		2.3 (4pm)	2.3	2.3			6.9
3) 3 health educators (same as above)		2.3	2.3	2.3			6.9
4) 3 social agents (same as above)		2.3	2.3	2.3			6.9
5) Center Director (clinical Mgmt 3 mos. in U.S. plus \$1.5 for int'l trsp.)			5.4				5.4
6) Researcher/evaluator (Res/Eval'n same as above)			5.4				5.4
Sub-total		<u>16.4</u>	<u>27.2</u>	<u>16.4</u>	<u>9.5</u>		<u>69.5</u>

D. Local cost

Research Funds				20	20	10	50
Sec'y (bilingual)				10	10		20
Oper. Cost (vehicle maint.)				<u>5</u>	<u>5</u>	<u>5</u>	<u>15</u>
Sub-total				<u>35</u>	<u>35</u>	<u>15</u>	<u>85</u>

<u>TOTAL FPIA</u>		<u>16.4</u>	<u>125.2</u>	<u>180.4</u>	<u>139.5</u>	<u>83</u>	<u>544.5</u>
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ANNEX C-1

\$000

	Sept 77	10/77-78	10/78-79	10/79-80	10/80-81	10/81-82	10/82-83	Total \$
	FY 77	FY 78	FY 79	FY 80	FY 81	FY 82	FY 83	
III. GOT								
A. Land	25							25.0
B. Personnel: staff salaries			22.6	74.4	109.1	120.0	133	459.1
C. Training (per diem & transport)				23.4	26.7	30	30	110.1
D. Operating cost								
Utilities (elect. water, telephone)			5.	22.5	30	32	34	123.5
Medicine, pharm. supplies				20	21	22	23	86
Vehicle maint. & POL					2.5	2.5	2.5	7.5
Misc. sterilization (laundry, uniforms, oxygen, etc.)				5	6	7	8	26
TOTAL GOT	25		27.6	145.3	195.5	2 135	230.5	837.2
IV. UNFPA								
3 vehicles (passenger) and spares			45					45
Mobylettes & bicycles			5					5
TOTAL UNFPA			50					50
GRAND TOTAL	1,213.3	16.4	202.8	325.7	334.8	296.5	230.5	2,620.0

ANNEX C-1

Project Costs

Architectural design costs are estimated to be approximately \$50,000. Total construction costs are estimated to be \$497,000 (1420 m² @ \$350./m²). It is anticipated that Center construction will be completed approximately two years from the signing of the Project Agreement. Therefore an inflation factor of 20% for 2 years was added to construction costs. A contingency factor of 10% of construction cost including inflation was added, raising total construction costs to \$789,000.

AID furniture and equipment costs are estimated to be \$118,400. (This figure includes 50% CIF). As furniture and equipment will not be ordered for at least one year, a 10% inflation factor as well as a 7% procurement fee were added to the base costs. Local currency authorization is requested in the amount of \$10,000 which raises total furniture and equipment costs to \$149,300.

The U.S. technician's services are estimated to be \$90,000 per year for 2 years. The bilingual secretary's services are estimated to be \$10,000 per year for 2 years.

FPIA financed short-term consultants services are estimated at \$6,000 per person month.

Participant training in Africa is estimated at \$400 per month. Round-trip international air fare is estimated at \$700 per person. Participant training in the U.S. is estimated at \$1300 per month. Round trip international air fare is estimated at \$1500 per person.

Vehicle maintenance and POL are estimated at \$.25 per mile. The cost estimates are based on a total of 10,000 per year per vehicle.

The GOT staff salaries are based on the average 1977 salary for a particular category, e.g. physician, midwife, nurse, etc. As shown in Annex C1a a 10% inflation factor has been added each year to salaries as inflation in Togo is about 15% per year. The core staff of the Center will be involved in the selection of trainees, initial preparation of curriculum, educational materials, etc. for approximately three months in FY 79; therefore 25% of total salaries for FY 79 have been included in the budget. The Center is expected to be fully operational 9 months of FY 1980 (starting January), therefore 75% of total salaries for 1980 have been included in the budget.

ANNEX C-1 (cont'd)

Per diem was computed at the rate of \$5.00 per day per trainee; 30 days for senior level; and 14 days for mid-level. An average of \$15.00 per person was used to compute round-trip transport costs from rural health posts. Computations are based on the number of trainees (senior and mid-level) given in the logframe.

LOCAL STAFFING PATTERN AND ESTIMATED SALARIES

<u>TITLE</u>	<u>SALARIES IN 000's CFA</u>	
<u>Medical Facility</u>	Av. Salary for Grads (1977)	Total Annual Salary for class of personnel (1977)
Medical Director	1,860	1,860
1/3 Time OB-GYN/Pediatrician/GP	1,560	1,560
4 Midwives	960	3,840
3 Nurses (unf. d'etat)	960	2,880
2 Social assistants	600	1,200
2 Health educators (agent technique)	960	1,920
1 Laboratory technician	600	600
1 Asst. Lab technician	400	400
1 Pharmacy technician	700	700
1 Asst. pharmacy technician	500	500
1 Medical record clerk	400	400
1 Librarian	800	800
1 Evaluator/researcher	800	800
<u>Support Staff</u>		
2 Secretaries	400	800
1 Receptionist	300	300
4 Janitors/cleaners	250	1,000
2 Nightwatch	250	<u>500</u>
	Total CFA	20,060,000
Conversion to \$s at 245 CFA=\$1.00	Total	\$81,878
	Rounded out	\$82,000

ANNEX C-1a

PROJECTIONS FOR LOCAL STAFFING PATTERNS AND ESTIMATED SALARIES

	Theoretical FY 1978	Theoretical FY 1979	Theoretical FY 1980	Theoretical FY 1981	Theoretical FY 1982	Theoretical FY 1983
Staffing Pattern as attached	82,000	82,000	90,200	99,220	109,142	120,056
Inflation 10%		<u>8,200</u>	<u>9,020</u>	<u>9,922</u>	<u>10,914</u>	<u>12,005</u>
		90,200	99,220	109,142	120,056	133,061
		25% 22,550	75% 74,415			

→ Dr. Poulsen

-84-

ANNEX C-2

OPTIONAL FORM NO. 10
JULY 1973 EDITION
GSA FPMR (41 CFR) 101-11.6

UNITED STATES GOVERNMENT

Memorandum

TO : Mr. Richard Dudley, Chief Engineer DATE: 6 May 1977

FROM : Robert M. Duncan, Civil Engineer
Consultant, AID/REDSO/WA *R.M. Duncan*

SUBJECT: Family Health Center, Lomé, Togo.

Scope of Work

To assist in the planning and layout of a simple clinic with facilities to include the teaching of Togolese personnel improved maternal and child care services, nutrition education, and family planning.

Specific requirements of the assignment (resulting from an oral briefing by Mr. Van Raalte) were:

Determinations required:

1. Location and size of the proposed construction site.
2. Location of nearest city utilities to the site, power lines, water lines, and sewer lines.
3. The capability of Togolese Architects and Engineers to design the facility.
4. The capability of Togolese contractors to construct the facility on a firm time schedule.
5. The availability of construction materials which would be required for the facility.

To work with REDSO personnel, Dr. Poulsen and Dr. Mackie to determine:

1. Space requirements.
2. Flow pattern of patients through the clinic.
3. Clinical equipment to be used.
4. Need for audio-visual rooms.
5. Need for air conditioning.
6. ~~Maximum day flow of patients.~~ *PARKING SPACE FOR CARS*



Buy U.S. Savings Bonds Regularly on the Payroll Savings Plan

7. Maximum day flow of patients through the clinic.

Determinations made:

1. Attached is a partial map of the City of Lomé showing the location of the proposed site.
2. An official survey of the proposed site showing the location of the city water and power lines and listing the coordinates of the corners of the proposed site is also attached.
 - a. Electric power is supplied to the City of Lomé from generation at the Akosombo Dam in Ghana. The house service voltage is 220 and 50 cycle. The supply from Akosombo is constant but occasional outages occur due to failures in the Lomé distribution system.
 - b. The city water supply is pumped from wells and is treated at the source. To insure against possible pollution entering the water due to breaks in the distribution system, the drinking water for the clinic should be treated.
 - c. No sewage collection system exists in the clinic area of Lomé. A septic tank together with a leaching well will need to be constructed in which to dispose of toilet wastes from the clinic. No percolation tests were made at the site but the area is a sand deposit and tests should be made to determine how deep the sand extends. At the U.S. Embassy compound, steel rods were driven easily to a depth of sixteen feet through cohesionless sand. A similar test could be made at the clinic site to determine the depth of the sand.

A drawing of the type of septic tank being constructed in Lomé was obtained from Service National D'Assainissement, Lomé. A copy is attached.
3. Two Togolese architects were visited, Mr. Locoh and Mr. Alcide da Silva. Both men are Togolese and were educated in France. After observing drawings and calculations, the conclusion was reached that each has the technical capability to prepare architectural and structural design

drawings and specifications for the Health Center.

The Togolese practice is to prepare drawings with only the dimensions shown and no details. The details are covered in the written specifications and structural design calculation sheets.

The contractors who wish to bid for the construction work are each given a set of drawings, specifications and the structural design calculation sheets. Each contractor is required to present with the bid the details for construction, such as the shape, size, number and position of the steel reinforcing bars.

This is forcing each contractor to repeat the work already done by the engineer and the cost of this work is included in the contractor's bid. I suggest that when REDSO negotiates with the architect that the agreement be made with the architect to show all details on the drawings and let the written specifications control the quality of the work and materials.

4. The two architects mentioned above informed me that Togolese contractors have the capability to construct the Health Center on a fixed schedule. Architect da Silva recommended the following Togolese contractors:

Clarence Olympio, Entrepreneur
EGTP, Mr. Ajavon
Travaux Atlantique, Amarin

Mr. Locoh is a builder as well as an architect.

5. The following local construction materials are available at the prices listed: (Note: these quotations were obtained from the two architects). Mr. Locoh's quotations apply to the prices during April 1977. Mr. da Silva's quotations are the prices charged by the Government after May 1, 1977.

<u>Item</u>	<u>Unit</u>	<u>CFA UNIT PRICE</u>	
		Mr. Locoh	Mr. Da Silva
Cement	ton	12,000	20,000
Sand	M ³		1,500
Gravel	M ³		6,000
Reinforcing Steel	ton	160,000	250,000
Marble 1" thick	M ²		8,000

4

Ceramic tile			
5/16" thick	M ²		
Interior wood doors	ea	6,000	4,000
Exterior wood doors	ea	12,000	
Form lumber	M ³		14,000

Corrugated cement-asbestos sheets
Corrugated galvanized steel sheets
Corrugated aluminum sheets

6. The preparation of the floor plan of the Health Center was made possible by the cooperation, advice, and suggestions of Dr. Poulsen and Dr. Anita Mackie.

Each architect was asked for his estimate of the unit cost of a building similar to the Health Center.

Mr. Lccoh's estimate of 100,000 CFA per square meter was based on a building without an interior finish (\$200 per square meter).

Buildings of this type including the interior finish and equipment are being constructed for \$330 per square meter in the United States.

The total floor area of the Health Center as shown on the attached sketch is 1,422 square meters.

Estimated cost:

at \$330 per square meter	\$469,200
at \$400 per square meter	\$568,800

The following persons were contacted in Lomé during the preparation of this report:

1. Mrs. Sally Sharp, AID Representative, Lomé.
2. Mr. Adama, Chef du Service Topographique, Lomé.
3. Mr. Creppe, Asst. Chef du Service Topographique, Lomé.
4. Mr. Lccoh, Architect and Builder, Lomé.
5. Mr. Woolwine, Administrative Officer, U.S. Embassy, Lomé.
6. Mr. Acide da Silva, Architect-Engineer, Lomé.
7. Mr. Amigee, Chef du Service d'Assainissement, Lomé.

Two meetings were held for discussion regarding the project with the U.S. Ambassador. Those attending the meetings were:

Ambassador Palmer
Sally Sharp, AID representative,
Dr. Poulsen, REDSO
Dr. Mackie, REDSO
R. M. Duncan, REDSO Engineer
William Young, CDO

-84d-

5

The following documents are attached:

1. Map of part of the City of Lomé showing the location of Health Center site.
2. Official survey of the site.
3. Fosse Septique A. Sortie Horizontal.
4. Contrat D'Architecte.
5. Plan of Health Center by R. M. Duncan.
6. Copy of calculations of site area.
7. Outline of Togo Architectural Contracts.

Furniture and Equipment Summary by Room

Offices:

1 Project Directors	\$	3,610
9 Administrative and Teaching Staff		4,500
2 Secretarial and Office Equipment		5,500

Medical:

Treatment Room		1,515
Recovery Room		960
Storage/Cleaning/Supply Room		1,400
Laboratory		5,070
Family Planning Conference Room		510
Pharmacy		3,700
Examining Rooms (8)		4,800
Waiting Room		2,800
Record Storage Room		700

Teaching:

Auditorium		14,900
Classrooms		9,400
Library		7,500
Students Lounge		8,000

Summary:

Office area \$14,000 + 50% CIF		21,000
Medical items (old catalogue 25% adjustment) \$24,100 + 50% CIF		36,200
Teaching Area \$40,000 + 50%		61,200
		<hr/>
	\$	118,400

Furniture and Equipment List
Togo Family Health Center

Auditorium

Seats for 100 persons with writing shelf (collapsible) @ \$100	\$ 10,000
Table for Lecturers + 4 chairs	600
Podium with built-in mike plus light	500
Large built-in retractible screen	400
Large stand-alone green chalkboard	400
Three Unit Airconditioners @ \$1,000	3,000
	<hr/>
	\$ 14,900

Classrooms

20 Desks and Chairs @ \$200	4,000
Lecturer's Table plus 2 Chairs	500
Large Green Chalkboard - moveable	150
Large Corkboard for Notices, etc.	50
	<hr/>
	\$ 4,700

Two Classrooms @ \$4,700: \$9,400

Library

Moveable and adjustable Bookshelf Units	3,000
Four Round Tables to seat 4 Persons Each	3,000
Small Desk plus Chair-Librarian	300
Six Easy Chairs for Reading @ \$200.	1,200
	<hr/>
	\$ 7,500

Students' Lounge

25 Steel Clothing Lockers for padlocks @ \$60.	\$ 1,500
8 Easy Chairs @ \$200.	1,600
2 Sofas @ \$1,500	3,000
2 Tables to seat 4 persons each	1,500
2 Coffee Tables	400
	<hr/>
	\$ 8,000

Examining Room

Examining Table	320
Treatment Cabinet	125
Operator Stool	35
Waste Receiver	20
Examining Lamp	50
1 Chair	40
	<hr/>
	\$ 600

8 Examining Rooms @ \$600. = \$4,800

Recovery Room

Recovery Couch	200
Chair	40
	<hr/>
	\$ 240

Laboratory (40' wall space)

Counter height steel laboratory
base units

2 Double Cupboard @ \$150.	\$ 300
4 4-Drawer Units @ \$155.	620
2 Sink Units @ \$95.	<u>190</u>
	1,110
2 20' Units @ \$1,110	2,220
2 Basic Laboratory Monocular Microscopes @ \$500.	1,000
1 Biological Refrigerator - 6 cu.ft.	350
Small Equipment - Centrifuges, etc.	500
1 Airconditioner	<u>1,000</u>
Medical:	\$5,070

Pharmacy

8' of high cabinets @ \$100/ft	800
8' of counter high bases @ \$75/ft	600
1 sink unit	100
1 desk unit	200
Refrigerator with separate freezer door	500
Small equipment	500
1 airconditioner	1,000

Treatment Room

Refrigerator	<u>3,700</u>
	500
Treatment Table	200
Treatment Cabinet	125
Storage and Supply Cabinet	350
Instrument Cabinet	200

Utility Table	60
2 Chairs	80
	<hr/>
	\$ 1,515
Storage/Cleaning Supply Room	
8' of high cabinets @ \$100/ft	800
1 Omniclave Sterilizer	500
1 Sink Unit	100
	<hr/>
	\$ 1,400
Waiting Room	
Weighing Area	
1 Utility Table for Pediatric scale	100
1 Continental Clinic Scale - infants and children	100
1 Physician's Scale w/height rod	100
50 Chairs, stackable plastic @ \$50	2,500
	<hr/>
	\$ 2,800
Record Storage Room	
Shelves or Filing Cabinets for Records	500
Small Desk plus Chair	200
	<hr/>
	\$ 700

Family Planning Conference Room

Round Table for Six	\$ 100
6 Chairs @ \$60.	360
Small Chalkboard	50
	<hr/>
	\$ 510

Offices

Project Director	
Executive Desk	\$ 680
Executive Chair	183
1 Seminar/Meeting Table	85
6 Chairs for above Table	1,002
2 Easy Chairs @ \$207	414
1 Bookcase, 3 shelf	245
1 Airconditioner	1,000
	<hr/>
	\$ 3,609

Teaching and Administrative Staff

Desk-single Pedestal	\$ 185
3 Chairs @ \$35	105
Bookcase - 2 shelves	47
2 Drawer File - Legal Size	90
Large Corkboard	40
	<hr/>
	\$ 467

9 Offices @ \$500 each: \$4,500

Secretarial Offices

Secretarial Desk	\$ 206
Bookcase - 2 shelves	47
File - 5-drawer - legal	143
Chair	46
	<hr/>
	\$ 442

2 Offices at \$450. each: \$900.

Office Equipment:

1 Manual Typewriter	500
1 Electric Typewriter IBM Selectric	1,100
1 Photocopier with capacity for transparencies	3,000
	<hr/>
Secretaria and Office Equipment \$5,500.	\$ 4,600

ANNEX C-4

PERSONNEL EMPLOYED IN MINISTRY OF HEALTH
TOGO, 1976

<u>Category</u>	<u>Number</u>
Physicians	100
Pharmacists	10
Dentists	4
Sanitary Engineers	3
Hospital Administrators	8
Physicians' assistants	48
Laboratory technicians	5
Technical agents in health	165
Technical agents in sanitation	14
State nurses	521
Midwives	201
Assistant sanitarians	78
Laboratory assistants	75
Auxilliary nurses	168
Auxilliary midwives	322
Travelling nurses (Agents itinerants)	148

Draft Project Description to be Used in the Project Agreement

This is an international joint effort between the United States Agency for International Development (AID), Family Planning International Assistance (FPIA), the international division of Planned Parenthood Federation of America, Inc., and the Government of Togo (GOT), particularly the Ministry of Health, Social Affairs and the Advancement of Women (MOH). The project will assist the GOT in strengthening its institutional capacity to provide improved health services to its populace, particularly pregnant and lactating mothers and children 0-5 years of age. With five out of ten children dying before they reach the age of five in rural areas of Togo, there can be little doubt about the need for improving maternal and child health services.

This objective will be accomplished through the in-depth training and/or retraining of medical, paramedical and social personnel of the MOH in the various aspects of family health, i.e. maternal child health, nutrition education and family planning. The project does not address all phases of the Togolese health services, but is limited to provide better training, understanding of and reorientation towards family health to all health personnel.

The project will be implemented under the aegis of the MOH. An AID-financed technician and his Togolese counterpart, the Director of Family Health Center, will be primarily responsible for day-to-day management and implementation of the project. They will coordinate all donor inputs and monitor project progress and adherence to the conditions agreed upon by all donors.

This is a six year project. However, AID funds will be disbursed over the first three years of the project. The AID contribution will consist of financing for (i) the design and construction of the Center, (ii) furniture and equipment for the Center, (iii) the services of a public health advisor and a bilingual secretary.

FPIA will finance the entire training component of the project. This will include: (i) approximately 29 person months (PM) of short-term technical assistance; (ii) approximately 102 PM of short-term participant training; (iii) commodities and equipment; (iv) some local cost (research funds and a bilingual secretary); and (v) a portion of operating cost (vehicle maintenance and POL).

The GOT contribution will consist of (i) land for the Center site; (ii) salaries of full and part-time Center staff; (iii) per diem and transportation of trainees; and (iv) operational cost of the Center.

Training Curriculum (Knowledge to be Acquired)

1. Relationship between MCH and Family Planning

2. Methods of Family Planning:

- a. Oral contraceptives
- b. Intrauterine devices
- c. Sterilization - Male and Female
- d. Condoms
- e. Foams/Jellies
- f. Natural methods

(Indications, contraindications, complications and side effects follow-up and referral systems.)

3. Fertility and Sub-Fertility (the latter sometimes referred to as infertility - a serious problem in West Africa).

4. Maternal Health.

- a. Pelvic anatomy and physiology
- b. Ante-natal care - selection of high risk patients
- c. Vaginal examinations - abnormal findings
- d. Vaginal discharge and treatment

5. Reasons for High Infant Mortality in Togo.

- a. Lack of vaccinations
- b. Ineffective health education at home
- c. Poor nutrition
- d. Compact birth

- e. Infection
- 6. The quality of life as it relates to the health, social and economic aspects of family planning.
- 7. Maternal and child health/family planning information and education.
- 8. Organization of a MCH/FP clinic.
 - a. Maintenance of equipment and supplies
 - b. Record keeping/statistics
 - c. Establishment of clinic hours
 - d. Patient referral and follow-up system
 - e. Logistics

Skills to be Acquired in Training Program

- 1. Rapport with patients - counselling - education
- 2. Medical examination, including:
 - a. Cardio-vascular system (blood pressure recording)
 - b. Breasts
 - c. Legs - for varicose veins
 - d. Pelvic
 - e. Speculum examination
- 3. Insertion of IUD's (each trainee should insert a minimum of six under supervision)
- 4. Microscopy for:
 - a. Trichomonas vaginalis
 - b. Gonococcus
- 5. Care and sterilization of instruments and IUD's.

6. Communication and education skills.
 - a. Ability to listen to people
 - b. Ability to teach (interview, advise, guide)
 - c. Ability to prepare and use various media for teaching and learning
 - d. Writing reports and setting up discussion groups
 - e. Group work (assignments)
7. Development of information/education materials teaching aids
 - a. Trainees, assisted by local resource people and advisors should develop their own materials based upon past MCH/FP field experience and knowledge acquired while in training.
 - b. Simple but meaningful patient handouts.

INITIAL ENVIRONMENTAL EXAMINATION

PROJECT LOCATION: Lome, Togo
PROJECT TITLE: Togo Family Health
FUNDING: FY 77
LIFE OF PROJECT: Six years
IIE PREPARED BY: Richard Dudley, Chief Engineer,
REDSO/WA

ENVIRONMENTAL ACTION RECOMMENDED:

Negative Determination

CONCURRENCE: Sally Sharp, AID Affairs Officer,
Lome

ASSISTANT ADMINISTRATORS/DIRECTORS DECISION:

I. EXAMINATION OF NATURE, SCOPE AND MAGNITUDE OF ENVIRONMENTAL IMPACTS:

A. Project Description

This is an international joint effort between the United States Agency for International Development (AID), Family Planning International Assistance (FPIA), the international division of Planned Parenthood Federation of America, Inc., and the Government of Togo (GOT), particularly the Ministry of Health. The project will assist the GOT in strengthening its institutional capacity to provide improved health services to its populace, particularly pregnant and lactating mothers and children 0-5 years of age.

This objective will be accomplished through the in-depth training and/or retraining of medical, paramedical and social personnel of the MOH in the various aspects of family health, i.e. maternal child health, nutrition education and family planning.

The central part of this effort, to be financed by AID in the establishment of a Family Health Center in the Be District of Lome, a densely populated semi-urban low income area. The Center will cover approximately 1400 square meters including limited off-street parking facilities. The Center will include clinic facilities for: pre- and

post-natal examinations and consultations; child spacing consultations and treatment; examinations and treatment for problems of infertility; and pediatric consultation and well-child care including immunizations, nutrition control and nutrition education and laboratory and pharmacy facilities. The educational facilities will include two classrooms to accommodate 20 persons each and an auditorium with audio-visual equipment for conferences, lectures, seminars and workshops, a lounge for students, a library and offices. The clinical facilities will be designed for easy and efficient flow of patients and will be able to handle up to 200 patients a day. A detailed floor plan of the proposed Center is attached as part of Annex

II. IDENTIFICATION AND EVALUATION OF ENVIRONMENTAL IMPACTS

A. Environmental Aspects Investigated

1. Land Use.

The land to be utilized is in a heavily populated urban area in the capital city of Togo. No detrimental effect to the environment will occur through the construction of a health facility on this site. As the center will cater primarily to the needs of the poorer people of the city, no notable generation of vehicular traffic in the area is anticipated.

2. Water Quality

The project will not contribute to contamination to sources of water in any way. No sewers exist in the area, but the construction of the clinic will include the construction of a septic tank and leaching system. The soils in the area are highly permeable sand, with no known water table within 50 meters of the surface, and no known wells or other sources of usable sub-terrainian water in the area. Where sewerage facilities do exist in this section of Lome, such facilities consist of pit privies or seepage pits, both of which provide a basis for far more contamination to possible water sources than the system contemplated for the health center.

C. Atmospheric

No known aspect or result of this project would have an effect on the atmosphere.

D. Natural Resources

The project does not contemplate an effect whatsoever on the natural resources in Togo.

E. Cultural and Social

No noticeable impact on cultural patterns of the Togolese is anticipated as a result of this project although very little family planning is practiced in Togo, as stated in the Social Analysis rural women are willing to have access to family planning techniques provided they are approached in the right manner.

After five years of full operation, the family health program will affect primarily two population groups. For women in the child-bearing years, the likelihood exists that the following changes will occur: a) a decline in maternal mortality; b) a reduction in the age-specific birth rates for the youngest age groups (10-14 and 14-19); and c) an increasing birth interval between children. For babies and infants, the following changes may occur: a) a light reduction in the crude birth rate; and b) increasing survival rates in the 0-1 age group and 1-4, resulting in a slight narrowing of the base of the population pyramid.

There are presently about 20 families living on the proposed Center site. They are squatters and have been notified by GOT officials that they will have to move. The GOT has agreed to assist these families to relocate. This problem will be addressed during negotiations of the Project Agreement.

F. Health

The primary benefits of this project will accrue to women in the childbearing years and children 0-5 years of age who receive family health services. However, indirectly the majority of the population will benefit from the training programs and health educational services provided by this project. In the long run this project will result in: a) a decrease in the high perinatal and child mortality rates; b) a decrease in the incidence of parasitic infections and preventable communicable diseases; and c) improved nutritional status of mothers and children. No negative environmental effects on the health of the Togolese populace are foreseen as a result of this project.

III. RECOMMENDATION FOR THRESHOLD DECISION

An investigation of pertinent aspects of the project, as presented, has indicated that no significant effects on the environment will occur as a result of its implementation, therefore a Negative Determination is appropriate.

IMPACT IDENTIFICATION AND EVALUATION
FORM

<u>Impact Areas and Sub-areas</u> 1/	Impact Identification and Evaluation 2/
A. LAND USE	
1. Changing the character of the land through:	
a. Increasing the population-----	<u> L</u>
b. Extracting natural resources-----	<u> N</u>
c. Land clearing-----	<u> N</u>
d. Changing soil character-----	<u> N</u>
2. Altering natural defenses-----	<u> N</u>
3. Foreclosing important uses-----	<u> N</u>
4. Jeopardizing man or his works-----	<u> N</u>
5. Other factors	
_____	_____
_____	_____
B. WATER QUALITY	
1. Physical state of water-----	<u> N</u>
2. Chemical and biological states-----	<u> L</u>
3. Ecological balance-----	<u> N</u>
4. Other factors	
_____	_____
_____	_____

1/ See Explanatory Notes for this form.

2/ Use of the following symbols: N - No environmental impact
L - Little environmental impact
M - Moderate environmental impact
H - High environmental impact
U - Unknown environmental impact

IMPACT IDENTIFICATION AND EVALUATION FORM

2

C. ATMOSPHERIC

- 1. Air additives----- N
 - 2. Air pollution----- N
 - 3. Noise pollution----- N
 - 4. Other factors-----
-

D. NATURAL RESOURCES

- 1. Diversion, altered use of water----- N
 - 2. Irreversible, inefficient commitments--- N
 - 3. Other factors
-
-

E. CULTURAL

- 1. Altering physical symbols----- N
 - 2. Dilution of cultural traditions----- L
 - 3. Other factors
-

F. SOCIOECONOMIC

- 1. Changes in economic/employment patterns L
 - 2. Changes in population----- L
 - 3. Changes in cultural patterns----- L
 - 4. Other factors
- Resettlement L
-

IMPACT IDENTIFICATION AND EVALUATION FORM

G. HEALTH

- | | |
|--|-----------------------|
| 1. Changing a natural environment----- | <u> M+ </u> |
| 2. Eliminating an ecosystem element----- | <u> N </u> |
| 3. Other factors | |
| _____ | _____ |
| _____ | _____ |

H. GENERAL

- | | |
|--------------------------------|----------------------|
| 1. International impacts----- | <u> N </u> |
| 2. Controversial impacts----- | <u> N </u> |
| 3. Larger program impacts----- | <u> N </u> |
| 4. Other factors | |
| _____ | _____ |
| _____ | _____ |

I. OTHER POSSIBLE IMPACTS (not listed above)

_____	_____
_____	_____

AID HANDBOOK 3, App 6C	TRANS. MEMO NO. 3:11	EFFECTIVE DATE November 10, 1976	PAGE NO. 6C(1)-1
------------------------	-------------------------	-------------------------------------	---------------------

6C(1) - COUNTRY CHECKLIST

Listed below are, first, statutory criteria applicable generally to FAA funds, and then criteria applicable to individual fund sources: Development Assistance and Security Supporting Assistance funds.

A. GENERAL CRITERIA FOR COUNTRY

- | | |
|--|--|
| 1. <u>FAA Sec. 116.</u> Can it be demonstrated that contemplated assistance will directly benefit the needy? If not, has the Department of State determined that this government has engaged in consistent pattern of gross violations of internationally recognized human rights? | Yes. Project will strengthen delivery of preventative family health care services and information throughout Togo. |
| 2. <u>FAA Sec. 481.</u> Has it been determined that the government of recipient country has failed to take adequate steps to prevent narcotics drugs and other controlled substances (as defined by the Comprehensive Drug Abuse Prevention and Control Act of 1970) produced or processed, in whole or in part, in such country, or transported through such country, from being sold illegally within the jurisdiction of such country to U.S. Government personnel or their dependents, or from entering the U.S. unlawfully? | No, such a determination has not been made. |
| 3. <u>FAA Sec. 620(a).</u> Does recipient country furnish assistance to Cuba or fail to take appropriate steps to prevent ships or aircraft under its flag from carrying cargoes to or from Cuba? | No such assistance is provided Cuba. |
| 4. <u>FAA Sec. 620(b).</u> If assistance is to a government, has the Secretary of State determined that it is not controlled by the international Communist movement? | The Secretary of State has not determined country is controlled by the international Communist movement. |
| 5. <u>FAA Sec. 620(c).</u> If assistance is to government, is the government liable as debtor or unconditional guarantor on any debt to a U.S. citizen for goods or services furnished or ordered where (a) such citizen has exhausted available legal remedies and (b) debt is not denied or contested by such government? | No. |
| 6. <u>FAA Sec. 620(e) (1).</u> If assistance is to a government, has it (including government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities? | No. |

PAGE NO. 6C(1)-2	EFFECTIVE DATE November 10, 1976	TRANS. MEMO NO. 3:11	AID HANDBOOK 3, App. 6C
---------------------	-------------------------------------	-------------------------	-------------------------

A

7. FAA Sec. 620(f); App. Sec. 108. Is recipient country a Communist country? Will assistance be provided to the Democratic Republic of Vietnam (North Vietnam), South Vietnam, Cambodia or Laos? No.
8. FAA Sec. 620(i). Is recipient country in any way involved in (a) subversion of, or military aggression against, the United States or any country receiving U.S. assistance, or (b) the planning of such subversion or aggression? No.
9. FAA Sec. 620(j). Has the country permitted, or failed to take adequate measures to prevent, the damage or destruction, by mob action, of U.S. property? No.
10. FAA Sec. 620(l). If the country has failed to institute the investment guaranty program for the specific risks of expropriation, inconvertibility or confiscation, has the AID Administrator within the past year considered denying assistance to such government for this reason? Togo has not failed to institute the investment guaranty program.
11. FAA Sec. 620(o); Fishermen's Protective Act, Sec. 5. If country has seized, or imposed any penalty or sanction against, any U.S. fishing activities in international waters, Togo has not seized nor imposed any penalty or sanction against U.S. fishing activities.
 - a. has any deduction required by Fishermen's Protective Act been made? No
 - b. has complete denial of assistance been considered by AID Administrator? No
12. FAA Sec. 620(q); App. Sec. 504. (a) Is the government of the recipient country in default on interest or principal of any AID loan to the country? (b) Is country in default exceeding one year on interest or principal on U.S. loan under program for which App. Act appropriates funds, unless debt was earlier disputed, or appropriate steps taken to cure default? No
13. FAA Sec. 620(s). What percentage of country budget is for military expenditures? How much of foreign exchange resources spent on military equipment? How much spent for the purchase of sophisticated weapons systems? (Consideration of these points is to be coordinated with the Bureau for Program and Policy Coordination, Regional Coordinators and Military Assistance Staff (PPC/RC).) Military expenditures account for 8.3% of country budget. Approximately \$14.0 million in foreign exchange has been spent on military equipment since 1975. No sophisticated weapon systems have been purchased.

AID HANDBOOK 3, App 6C	TRANS. MEMO NO. 3:11	EFFECTIVE DATE November 10, 1976	PAGE NO. 6C(1)-3
------------------------	-------------------------	-------------------------------------	---------------------

A

- 14. FAA Sec. 620(t). Has the country severed diplomatic relations with the United States? If so, have they been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption? No
- 15. FAA Sec. 620(u). What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrearages taken into account by the AID Administrator in determining the current AID Operational Year Budget? Togo is current with its UN obligations.
- 16. FAA Sec. 620A. Has the country granted sanctuary from prosecution to any individual or group which has committed an act of international terrorism? No
- 17. FAA Sec. 666. Does the country object, on basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. there to carry out economic development program under FAA? No
- 18. FAA Sec. 669. Has the country delivered or received nuclear reprocessing or enrichment equipment, materials or technology, without specified arrangements on safeguards, etc.? No
- 19. FAA Sec. 901. Has the country denied its citizens the right or opportunity to emigrate? No

B. FUNDING CRITERIA FOR COUNTRY

1. Development Assistance Country Criteria

a. FAA Sec. 102(c), (d). Have criteria been established, and taken into account, to assess commitment and progress of country in effectively involving the poor in development, on such indexes as: (1) small-farm labor intensive agriculture, (2) reduced infant mortality, (3) population growth, (4) equality of income distribution, and (5) unemployment.

b. FAA Sec. 201(b)(5), (7) & (8); Sec. 208; 211(a)(4), (7). Describe extent to which country is:

(1) Making appropriate efforts to increase food production and improve means for food storage and distribution.

(2) Creating a favorable climate for foreign and domestic private enterprise and investment.

Current agricultural policy seeks balance between judicious combination of large and small farms to increase food production.

Project directly addresses infant mortality. Current Five Year Plan gives high priority to rural development.

Current Five Year Plan gives high priority to increased food production.

Investment code is quite liberal and one can repatriate profits.

PAGE NO. 6C(1)-4	EFFECTIVE DATE November 10, 1976	TRANS. MEMO NO. 3:11	AID HANDBOOK 3, App. 6C
---------------------	-------------------------------------	-------------------------	-------------------------

81b

- (3) Increasing the public's role in the developmental process.
- (4) (a) Allocating available budgetary resources to development.
(b) Diverting such resources for unnecessary military expenditure and intervention in affairs of other free and independent nations.
- (5) Making economic, social, and political reforms such as tax collection improvements and changes in land tenure arrangements, and making progress toward respect for the rule of law, freedom of expression and of the press, and recognizing the importance of individual freedom, initiative, and private enterprise.
- (6) Otherwise responding to the vital economic, political, and social concerns of its people, and demonstrating a clear determination to take effective self-help measures.

GOT plans to exploit development potentials of northern Togo to bring the populace into the mainstream of development process.

Goal of third 5-year development plan.

Negative, because development resources are financed by other donors.

GOT is addressing these concerns in its third 5-year development plan.

Major goals of third 5-Year Plan demonstrates support to these concerns.

c. FAA Sec. 201(b), 211(a). Is the country among the 20 countries in which development assistance loans may be made in this fiscal year, or among the 40 in which development assistance grants (other than for self-help projects) may be made?

Among the 40 in which development assistance grants will be made.

d. FAA Sec. 115. Will country be furnished, in same fiscal year, either security supporting assistance, or Middle East peace funds? If so, is assistance for population programs, humanitarian aid through international organizations, or regional programs?

No

2. Security Supporting Assistance Country Criteria

a. FAA Sec. 502B. Has the country engaged in a consistent pattern of gross violations of internationally recognized human rights? Is program in accordance with policy of this Section?

No

b. FAA Sec. 53i. Is the Assistance to be furnished to a friendly country, organization, or body eligible to receive assistance?

Yes

c. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made?

N/A

AID HANDBOOK 3, App 6C	TRANS. MEMO NO. 3:11	EFFECTIVE DATE November 10, 1976	PAGE NO. 6C(2)-1
------------------------	-------------------------	-------------------------------------	---------------------

6C(2) - PROJECT CHECKLIST

Listed below are, first, statutory criteria applicable generally to projects with FAA funds, and then project criteria applicable to individual fund sources: Development Assistance (with a sub-category for criteria applicable only to loans); and Security Supporting Assistance funds.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? IDENTIFY. HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT?

I. GENERAL CRITERIA FOR PROJECT.

1. App. Unnumbered; FAA Sec. 653(b)

(a) Describe how Committees on Appropriations of Senate and House have been or will be notified concerning the project;
(b) is assistance within (Operational Year Budget) country or international organization allocation reported to Congress (or not more than \$1 million over that figure plus 10%)?

Notification has been given in FY 1977 submission to the Congress Africa Programs, on page P295. The project is also listed in the FY 1978 Submission on page 233.

2. FAA Sec. 611(a)(1). Prior to obligation in excess of \$100,000, will there be (a) engineering, financial, and other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

a. Yes
b. Yes

3. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?

Further legislative action is not required.

4. FAA Sec. 611(b); App. Sec. 101. If for water or water-related land resource construction, has project met the standards and criteria as per Memorandum of the President dated Sept. 5, 1973 (replaces Memorandum of May 15, 1962; see Fed. Register, Vol 38, No. 174, Part III, Sept. 10, 1973)?

N/A

5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed \$1 million, has Mission Director certified the country's capability effectively to maintain and utilize the project?

Principal AID Officer in Togo has so certified.

PAGE NO. 6C(2)-2	EFFECTIVE DATE November 10, 1976	TRANS. MEMO NO. 3:11	AID HANDBOOK 3, App. 6C
---------------------	-------------------------------------	-------------------------	-------------------------

A.

6. FAA Sec. 209, 619. Is project susceptible of execution as part of regional or multi-lateral project? If so why is project not so executed? Information and conclusion whether assistance will encourage regional development programs. If assistance is for newly independent country, is it furnished through multi-lateral organizations or plans to the maximum extent appropriate?

Project will be funded and implemented thru multilateral organizations. Center will serve as demonstration center for West African countries and trainees from these countries.

7. FAA Sec. 601(a); (and Sec. 201(f) for development loans). Information and conclusions whether project will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.

- a. \$130,200 of commodities will be procured.
- b. Construction contract will be let on competitive basis.
- c. N/A
- d. N/A
- e. N/A
- f. N/A

8. FAA Sec. 601(b). Information and conclusion on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

Commodities from US total \$130,200
Technical assistance from US totals \$180,000.

9. FAA Sec. 612(b); Sec. 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized to meet the cost of contractual and other services.

GOT providing 81.4% of local currency cost. US will use any foreign currency available.

10. FAA Sec. 612(d). Does the U.S. own excess foreign currency and, if so, what arrangements have been made for its release?

No.

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FAA Sec. 102(c); Sec. 111; Sec. 281a. Extent to which activity will (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor-intensive production, spreading investment out from cities to small towns and rural areas; and (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions?

- a. Project will improve preventive health services available to Togolese population in rural areas.
- b. N/A

AID HANDBOOK 3, App 6E	TRANS. MEMO NO. 3:11	EFFECTIVE DATE November 10, 1976	PAGE NO. 6C(2)-3
------------------------	-------------------------	-------------------------------------	---------------------

B1

b. FAA Sec. 103, 103A, 104, 105, 106, 107. Is assistance being made available: [include only applicable paragraph -- e.g., a, b, etc. -- which corresponds to source of funds used. If more than one fund source is used for project, include relevant paragraph for each fund source.]

(1) [103] for agriculture, rural development or nutrition; if so, extent to which activity is specifically designed to increase productivity and income of rural poor; [103A] if for agricultural research, is full account taken of needs of small farmers;

(2) [104] for population planning or health; if so, extent to which activity extends low-cost, integrated delivery systems to provide health and family planning services, especially to rural areas and poor;

(3) [105] for education, public administration, or human resources development; if so, extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, or strengthens management capability of institutions enabling the poor to participate in development;

(4) [106] for technical assistance, energy, research, reconstruction, and selected development problems; if so, extent activity is:

(a) technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;

(b) to help alleviate energy problem;

(c) research into, and evaluation of, economic development processes and techniques;

(d) reconstruction after natural or manmade disaster;

(e) for special development problem, and to enable proper utilization of earlier U.S. infrastructure, etc., assistance;

(f) for programs of urban development, especially small labor-intensive enterprises, marketing systems, and financial or other institutions to help urban poor participate in economic and social development.

Project is specifically designed to strengthen the delivery of preventive family health care services and information throughout Togo.

PAGE NO. 6C(2)-4	EFFECTIVE DATE November 10, 1976	TRANS. MEMO NO. 3:11	AID HANDBOOK 3, App. 6C
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(5) [107] by grants for coordinated private effort to develop and disseminate intermediate technologies appropriate for developing countries.

c. FAA Sec. 110(a); Sec. 208(e). Is the recipient country willing to contribute funds to the project, and in what manner has or will it provide assurances that it will provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or has the latter cost-sharing requirement been waived for a "relatively least-developed" country)?

By provision in Grant Agreement GOT will contribute 30.4% of total project cost which includes land, salaries of center staff, per diem and transportation cost of trainees and other operational cost-

d. FAA Sec. 110(b). Will grant capital assistance be disbursed for project over more than 3 years? If so, has justification satisfactory to Congress been made, and efforts for other financing?

No

e. FAA Sec. 207; Sec. 113. Extent to which assistance reflects appropriate emphasis on; (1) encouraging development of democratic, economic, political, and social institutions; (2) self-help in meeting the country's food needs; (3) improving availability of trained worker-power in the country; (4) programs designed to meet the country's health needs; (5) other important areas of economic, political, and social development, including industry; free labor unions, cooperatives, and Voluntary Agencies; transportation and communication; planning and public administration; urban development, and modernization of existing laws; or (6) integrating women into the recipient country's national economy.

- 1) Assistance being provided to Ministry of Health and Social Affairs to strengthen its delivery of preventive health care services.
- 2) N/A
- 3) & 4) Project will train or re-train most of the MOH's medical and paramedical personnel.
- 5) N/A
- 6) Most trainees will be women.

f. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.

Project addresses major health problem of pregnant women, lactating mothers and their children 0-5 years of age (42% of population). Center will be fully staffed by trained Togolese.
N/A

AID HANDBOOK 3, App 6C	TRANS. MEMO NO. 3:11	EFFECTIVE DATE November 10, 1976	PAGE NO. 6C(2)-5
------------------------	-------------------------	-------------------------------------	---------------------

B1

g. FAA Sec. 201(b)(2)-(4) and -(8); Sec. 201(e); Sec. 211(a)(1)-(3) and -(8). Does the activity give reasonable promise of contributing to the development: of economic resources, or to the increase of productive capacities and self-sustaining economic growth; or of educational or other institutions directed toward social progress? Is it related to and consistent with other development activities, and will it contribute to realizable long-range objectives? And does project paper provide information and conclusion on an activity's economic and technical soundness?

Yes, project will contribute to development of educational and social institutions.

Yes, project related to and consistent with goal other development activities within the health sector and will contribute to realizable long-range objectives.

Yes.

h. FAA Sec. 201(b)(6); Sec. 211(a)(5), (6). Information and conclusion on possible effects of the assistance on U.S. economy, with special reference to areas of substantial labor surplus, and extent to which U.S. commodities and assistance are furnished in a manner consistent with improving or safeguarding the U.S. balance-of-payments position.

Effects on US economy will be minimal or non-existent. Project commodities and TA will be procured in U.S.

2. Development Assistance Project Criteria (Loans only)

a. FAA Sec. 201(b)(1). Information and conclusion on availability of financing from other free-world sources, including private sources within U.S.

N/A

b. FAA Sec. 201(b)(2); 201(d). Information and conclusion on (1) capacity of the country to repay the loan, including reasonableness of repayment prospects, and (2) reasonableness and legality (under laws of country and U.S.) of lending and relending terms of the loan.

N/A

c. FAA Sec. 201(e). If loan is not made pursuant to a multilateral plan, and the amount of the loan exceeds \$100,000, has country submitted to AID an application for such funds together with assurances to indicate that funds will be used in an economically and technically sound manner?

N/A

d. FAA Sec. 201(f). Does project paper describe how project will promote the country's economic development taking into account the country's human and material resources requirements and relationship between ultimate objectives of the project and overall economic development?

N/A

PAGE NO. 6C(2)-6	EFFECTIVE DATE November 10, 1976	TRANS. MEMO NO. 3:11	AID HANDBOOK 3, App. 6C
---------------------	-------------------------------------	-------------------------	----------------------------

B2

e. FAA Sec. 202(a). Total amount of money under loan which is going directly to private enterprise, is going to intermediate credit institutions or other borrowers for use by private enterprise, is being used to finance imports from private sources, or is otherwise being used to finance procurements from private sources? N/A

f. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete in the U.S. with U.S. enterprise, is there an agreement by the recipient country to prevent export to the U.S. of more than 20% of the enterprise's annual production during the life of the loan? N/A

3. Project Criteria Solely for Security Supporting Assistance N/A

FAA Sec. 531. How will this assistance support promote economic or political stability?

4. Additional Criteria for Alliance for Progress N/A

[Note: Alliance for Progress projects should add the following two items to a project checklist.]

a. FAA Sec. 251(b)(1), -(8). Does assistance take into account principles of the Act of Bogota and the Charter of Punta del Este; and to what extent will the activity contribute to the economic or political integration of Latin America? N/A

b. FAA Sec. 251(b)(8); 251(h). For loans, has there been taken into account the effort made by recipient nation to repatriate capital invested in other countries by their own citizens? Is loan consistent with the findings and recommendations of the Inter-American Committee for the Alliance for Progress (now "CEPCIES," the Permanent Executive Committee of the OAS) in its annual review of national development activities? N/A

AID HANDBOOK 3, App 6C	TRANS. MEMO NO. 3:11	EFFECTIVE DATE November 10, 1976	PAGE NO. 6C(3)-1
------------------------	-------------------------	-------------------------------------	---------------------

6C(3) - STANDARD ITEM CHECKLIST

Listed below are statutory items which normally will be covered routinely in those provisions of an assistance agreement dealing with its implementation, or covered in the agreement by exclusion (as where certain uses of funds are permitted, but other uses not):

These items are arranged under the general headings of (A) Procurement, (B) Construction, and (C) Other Restrictions.

A. Procurement

1. FAA Sec. 602. Are there arrangements to permit U.S. small business to participate equitably in the furnishing of goods and services financed? Solicitation of US technician will be made through Small Business Office of AID.
2. FAA Sec. 604(a). Will all commodity procurement financed be from the U.S. except as otherwise determined by the President or under delegation from him? Yes
3. FAA Sec. 604(d). If the cooperating country discriminates against U.S. marine insurance companies, will agreement require that marine insurance be placed in the U.S. on commodities financed? Yes
4. FAA Sec. 604(e). If offshore procurement of agricultural commodity or product is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? N/A
5. FAA Sec. 608(a). Will U.S. Government excess personal property be utilized wherever practicable in lieu of the procurement of new items? Use of said property not practical.
6. MMA Sec. 901(b). (a) Compliance with requirement that at least 50 per centum of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S.-flag commercial vessels to the extent that such vessels are available at fair and reasonable rates. Yes, compliance will be required with respect to any AID financed commodities.
7. FAA Sec. 621. If technical assistance is financed, will such assistance be furnished to the fullest extent practicable as goods and professional and other services from private enterprise on a contract basis? If the facilities of other Federal agencies will be utilized, Yes
N/A

PAGE NO. 6C(3)-2	EFFECTIVE DATE November 10, 1976	TRANS. MEMO NO. 3:11	AID HANDBOOK 3, App. 6C
---------------------	-------------------------------------	-------------------------	-------------------------

A7

are they particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?

8. International Air Transport. Fair Competitive Practices Act, 1974

If air transportation of persons or property is financed on grant basis, will provision be made that U.S.-flag carriers will be utilized to the extent such service is available?

Yes

B. Construction

1. FAA Sec. 601(d). If a capital (e.g., construction) project, are engineering and professional services of U.S. firms and their affiliates to be used to the maximum extent consistent with the national interest?

Due to size of job, waiver requested of Code 000 for Center architectural design and construction services.

2. FAA Sec. 611(c). If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable?

Yes.

3. FAA Sec. 620(k). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million?

N/A

C. Other Restrictions

1. FAA Sec. 201(d). If development loan, is interest rate at least 2% per annum during grace period and at least 3% per annum thereafter?

N/A

2. FAA Sec. 301(d). If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights?

N/A

3. FAA Sec. 620(h). Do arrangements preclude promoting or assisting the foreign aid projects or activities of Communist-Bloc countries, contrary to the best interests of the U.S.?

Yes

4. FAA Sec. 636(i). Is financing not permitted to be used, without waiver, for purchase, long-term lease, or exchange of motor vehicle manufactured outside the U.S. or guaranty of such transaction?

Yes

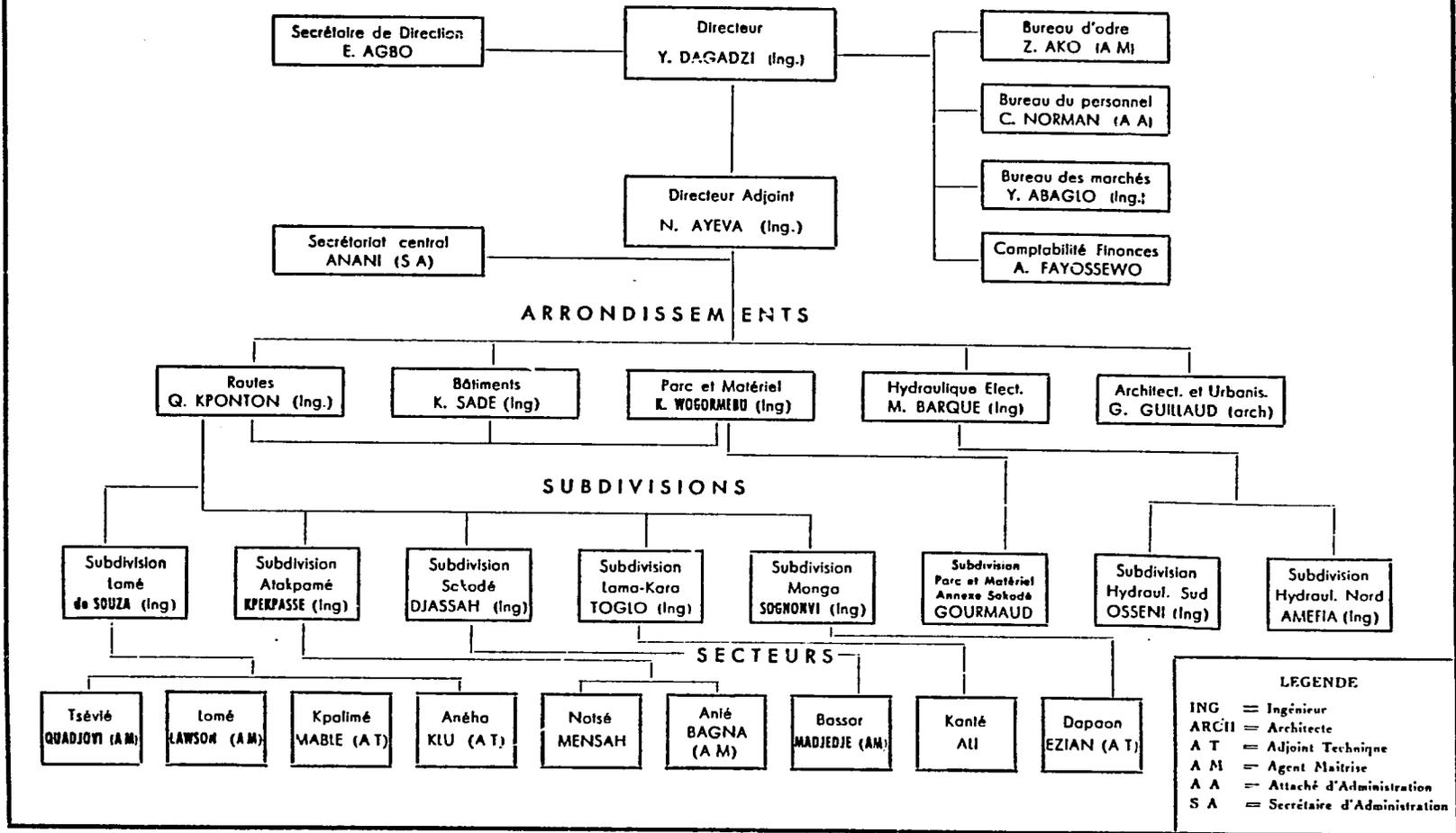
AID HANDBOOK 3, App 6C	TRANS. MEMO NO. 3:11	EFFECTIVE DATE November 10, 1976	PAGE NO. 6C(3)-3
------------------------	-------------------------	-------------------------------------	---------------------

- 5. Will arrangements preclude use of financing?
 - a. FAA Sec. 114. to pay for performance of abortions or to motivate or coerce persons to practice abortions? Yes
 - b. FAA Sec. 620(g). to compensate owners for expropriated nationalized property? Yes
 - c. FAA Sec. 660. to finance police training or other law enforcement assistance, except for narcotics programs? Yes
 - d. FAA Sec. 662. for CIA activities? Yes
 - e. App. Sec. 103. to pay pensions, etc., for military personnel? Yes
 - f. App. Sec. 106. to pay U.N. assessments? Yes
 - g. App. Sec. 107. to carry out provisions of FAA Sections 209(d) and 251(h)? (transfer to multilateral organization for lending). Yes
 - h. App. Sec. 501. to be used for publicity or propaganda purposes within U.S. not authorized by Congress? Yes

ORGANIGRAMME DU SERVICE DES TRAVAUX PUBLICS EN 1974
(AU 31 - 12 - 1974)

ANNEX G

-118-



KEY TO ANNEX H

Page 1

HEADINGS

- A) Description of the duties of each category of personnel of the S.S.B. (Services de Sante de Base - Basic Health Services).
- B) A.T.F. Fixed Technical Agent
- C) A.T.S. Technical Supervisor
- D) I.D.E. Nurse with State Diploma
- E) A.H. Hygiene Assistant
- F) A.A. Midwife Helper
- G) A.I. Mobile Helper

A.T.F.

Page 2

A. Administrative Duties

1. Organize the different services.
2. Plan all activities.
3. Provide medicines and other material for the different services.
4. Control their use.
5. Keep registers up to date.
6. Make reports.
7. Evaluate the various activities.
8. Supervise the personnel.
9. Coordinate with other Government Services.

B. Technical Duties

1. Diagnose and treat current illnesses.
2. Hospitalize and treat less serious cases.
3. Surveillance of patients.
4. Put the patients under the supervision of the doctor.
5. Help nurses to administer to the sick.

C. Educative Duties

1. Improve the skills of the staff.
2. Hold workshops on personal and community hygiene.
3. Help to teach stagiaires.

A.T.S.

Page 3

A. Administrative

1. Organize and plan his rounds.
2. Control work schedule of the staff.
3. Help to manage in the centers.
4. Evaluate these programs regularly.
5. Evaluate the staff.
6. Make reports and collect those made by the other categories of personnel.
7. Maintain good relations with the staff.
8. Coordinate activities.

B. Technical

1. Works in hospital units; give special medical care; makes home visits; keeps the work areas clean.
2. Collect samples for laboratory analysis.
3. Make epidemiological studies.
4. Assist the chief doctor.

C. Educative

1. Improve the skills of the staff.
2. Help to teach trainees.
3. Help in teaching health education.

I.D.E.

Page 4

A. Administrative

1. Organize and plan the work.
2. Establish a timetable.
3. Keep the department stocked with materials and medicine.
4. Control their use.
5. Ensure that work sites and materials are kept clean.
6. Keep registration papers and graphs up to date.
7. Assess the activities.
8. Make reports.
9. Coordinate activities.

B. Technical

1. Make sure to give consultations and remedies.
2. Provide first aid.
3. Evaluate serious illnesses.
4. Give vaccinations.
5. Keep the equipment sterilized.
6. Make home visits.
7. Make epidemiological studies.
8. Keep the work areas clean.

C. Educative

1. Improve the skills of auxiliary staff.
2. Teach personal and public health education and give demonstrations.
3. Teach stagiaires.

S.F.

Page 5

A. Administrative

1. Organize and plan the work.
2. Establish a timetable.
3. Keep the department stocked with materials and medicine.
4. Ensure the cleanliness and upkeep of the work area and materials.
5. Keep files, registration papers up to date.
6. Make reports.
7. Register births and deaths.
8. Coordinate activities.
9. Supervise the staff.

B. Technical

1. Make pre- and post-natal consultations.
2. Search out on time the dystocies.
3. Help with childbirth.
4. Take care of the new born children.
5. Surveillance of technical care.
6. Watch over the mother and child.
7. Give vaccinations.
8. Make home visits.

C. Educative

1. Improve the skills of auxiliary personnel.
2. Teach personal and public hygiene.
3. Teach the stagiaires.

A.H.

Page 6.

A. Administrative duties

1. Organize and plan activities.
2. Collect data.
3. Establish a timetable.
4. Make sure the department is supplied with work materials.
5. Keep the inventory up to date.
6. Make reports.
7. Ensure coordination with other departments.

B. Technical

1. Control quality and quantity of water used by the population.
2. Work out simple water supply systems.
3. Create a simple waste disposal system.
4. Control the quality of the food products.
5. Control the hygiene of the area. (Housing)
6. Control and localize disease-carrying animals which threaten the water supply.

C. Educative

1. Improve the skills of auxiliary staff.
2. Help to teach new personnel.
3. Practice health education.

A.A.

Page 7

A. Administrative

1. Establish a work program.
2. Keep records up to date.
3. Fill in report cards.
4. Register births and deaths.
5. File work documents.
6. Coordinate activities with the staff of the team.
7. Keep work areas and material clean.

B. Technical

1. Give pre- and post-natal consultations.
2. Help with non-complicated childbirths.
3. Give simple cures.
4. Learn as quickly as possible all the complications that can occur in childbirth and also the problems to expect with newborn children.
5. Evacuate cases when advised by the nurse.
6. Encourage mothers and children to visit the vaccination centers.
7. Make home visits.

C. Educative

1. Practice (give lessons in) personal and public health education.
2. Give cooking demonstrations, also care for mothers and pregnant women.

A.I.

Page 8

A. Administrative

1. Establish a timetable for field trips.
2. Keep maps of the area up to date.
3. List the population of pregnant women and breast fed children.
4. Register, out of centers, births and deaths.
5. Report infectious diseases and centers of epidemics.
6. Fill in report cards.
7. Coordinate activities with the other departments as well as with villagers.

B. Technical

1. Make home and school visits.
2. Know the geography of your region.
3. Search out and evacuate all sick people, pregnant women and newborn children.
4. Treat lepers and malaria cases when seen.
5. Give vaccinations.
6. Give first aid in emergencies.

C. Educative

1. Practice individual and public health education.
2. Animate and organize the local population.

July 25, 1977

Studies Done

A Socio-demographic survey of the Republic of Togo was carried out in 1969 by the Department of Sociology, University of Ghana in conjunction with the Department of Geography, Insitut de l'Enseignement Superieur du Benin (now Universite du Benin) Lome. The survey includes such health-related subjects as water supplies and refuse disposal, antenatal, postnatal and maternity practices, knowledge of, attitudes to and practice of family planning (KAP studies); and attitudes to, and extent of unwanted pregnancies and indused abortion. The findings of this survey provide the basis for the social analysis (Annex L)

As part of the preparatory efforts for an educational reform, the Ministry of National Education in 1969 commissioned the nation's Statistics Department to survey educational attitudes of some 10,000 Togolese. The sample group included: elementary, secondary and university students; elementary and secondary school teachers; literate adults who spoke French; and illiterate adults who did not speak French.

In response to the question "Do you want sex education taught in the schools?" 8,446 respondents answered "yes", while 1,506 said "no". Though the results of this were never published, a conferece of high-level Ministry of Education officials was convened in November, 1973 to discuss the findings of the survey. Participants in this meeting concluded that a comprehensive unit on family health that specifically included sex education should be developed and introduced to all grade levels.

In response to a request from the GOT in 1974, an AID financed consultant under contract to the American Public Health Association conducted a four month study of maternal child health and education prepared the design for the introduction of a national family planning program, "Projet National de Sante Familiale Pour Le Togo". The study recommended a national family health program which would include child spacing and be inter-ministerial in nature so as to provide the means to ensure the co-operation and coordination of educational and health sêrvice efforts. Specific recommendations included (a) replacing ineffectual and often unpopular home visits by health personnel with the organization and direction of village health communities; (b) providing in-service

training for all health personnel involved in teaching or delivering any aspect of family health; (c) introducing family health instruction as a separate course in the primary schools; (d) preference to include child spacing as an integral part of MCH services; and (e) the need for a medical facility to demonstrate integrated MCH/FP activities.

(C) Social Soundness Analysis

1) Socio-Cultural Feasibility

Who Lives Where

Togo does not find itself overpopulated, but population distribution is uneven. While there exist uninhabited regions to the west, population is dense in the coastal areas (124 inhabitants/Km² and in the LaKara zone: 58/Km².) A median density for the country is given as 38 persons/Km². But from a 1965 baseline, Togo is expected to double her population by 1985. A high growth rate of 2.7% is currently offset by childhood mortality in the region of 50%. With improving health facilities and accompanying reduction in mortality, Togo will have to look seriously to her Man/Land-Productivity ratios.

The following table gives population density by economic regions of Togo:

<u>Region</u>	<u>Area in Km²</u>	<u>Number of Inhabitants</u>	<u>Densities</u>
Maritime	6,395	794,087	124
Plateau	16,975	541,685	32
Central	20,450	322,632	16
Kara	43,625	252,355	58
Sarann	86,005	265,127	31
TOTAL	56,785	2,175,886	38

There are many tribes in Togo. Within large groups such as the coastal Ewe, even clans may signal their boundaries with different languages. Thus, a complicated language map appears. From out of this prodigality, three languages have become vehicular, or trade-tongues: to wit, Mina, spoken in the south, Kotokoli in the Central regions, and Kabiye in the north. In all, Togo counts 44 languages, and basically twelve cultures. Typical cultures will be, going north to south: at the north Moba and related groups such as the Mossi, Konkomba, Dya, Gurmanchi. These people occupy lands from the northern border south to below Mango. They well depress the border into Ghana.

To the south and east, in the region of Lakara, the Kabre (Kabiye) people exhibit a segmentary culture, marked by age-classes, famous for its warrior values, and generally considered less accessible than other parts of Togo to outside influence. The President, General Eyadema, comes from Pya, a village of this region. Related tribal groups are the Lamba, and Naoudemba.

Continuing south, radiating from the region of Sokode, live the Bassari, Kotokoli, and Tchamba peoples. Among them, live diverse groups of Muslims, immigrating from Niger and the Western Doudan. In this region Fulani cattle people who came from Nigeria in the 19th century, now live in symbiosis with the peasants, whose herds they guard.

In the Plateau region extending from Atakpame into Ghana, live the Akebou and Ntibou. Continuing south one comes to Akposso country with related groups of Fon, Ana, and Nina.

In the Maritime region, from Palime to the coast, predominant cultures are the Ewe and Nina, with many Fon as one approaches Dahomey.

This listing only includes major groups. There are many other pockets of minor ethnic groups often totally different in lifestyle values and social structure from the surrounding peoples. Incessant in-and-out migration, for historic (war), economic (exhaustion of lands), or social (tyranny of a particular Chief) reasons have dowered Togo with a fragmented social scene.

It is difficult for the foregoing reasons to define a religion, a set of values, a type social-structure for all of Togo.

Togo's populations divide geographically by tribal origin, stratify into "Class" structures by differential access to socially valued goods such as land-rights, rights to perform valued rituals; stratify into age-groups characterized by differing sets of rights and obligations. They differ further in outlook and behavior according to participation in modern or in traditional settings and activities. There is another major split along lines of rural vs. city life, of peasant vs. fonctionnaire. At the very fundamental base of all social life, are the diverging and complementary roles of man and woman with their differences in status, in rural and ritual rights, in occupation, possession, participation.

Nevertheless there are some basic themes.

Traditional Religion, Values, Norms

The family is the central motif, and the family extends in time beyond death and before birth. Therefore fertility, which protects the marginal and precarious life of Man is an ultimate value, not to be tampered with lightly.

The unit: Mother/Child is the generating node of Family and is seen as sacred. A woman's role has been defined as biological and nurturing. But control of her fecundity has been an ultimate political act. She will bear children, but to what group, to which family will they belong? What family will become strong with members? What lives will die out? These are such serious questions that all sexual behavior is stylized, emphasized, controlled. Sex roles are learned and formally conferred in "puberty schools" and "rites of passage". Elaborate symbolism and philosophy link the life, sexuality, and fecundity of Man with all that is generative in the universe: water, spirits and language.

One lives within the extended family, and in a hostile world. Social life is equal to survival. But if social life is to continue, there must be ways to minimize or control conflict. Conflict destroys the social groups which are the essential life-support system in all traditional societies. Therefore a soft-manner, gentle behavior, are valued norms in this society. Authority is more often persuasive than coercive. Most often authority is ritual.

Ancestors are just the part of the family that is across the dividing line of death. By crossing over, they have gained mystic power, and it is well understood that they use it to control the behavior of the living family members. They may well return, reincarnated in some family member still within a womb.

Elders within the family are nearest death, i.e., will soon accede to mystic, supernatural power. As such, they control the family shrines, which serve in some sense as "telephone" communication lines. Religious observance and ritual are at once ways to placate, and to manipulate the ancestors, as well as assorted non-related and ambiguous spirits which also people the crowded universe.

Here you see the essential lines of authority. Competent old age confers in power role. A strong personality, skilled in the politics of persuasion, manipulation, can lead a man to become a family, then lineage, then clan and tribal leader. Ultimately he will move across to become One-of-the-Ancestors-who Counts, i.e., who is specifically remembered. Other lesser ancestors meld into a sort of general fund. In life the powerful Elder controls access to land and economic life-support systems. Thereby he controls access to marriage-and-children, and thus to full social participation. After death, his righteous anger chastens and punishes immoral and asocial behavior. Thus, the in chastity adultery of a family wife will cause obstructed birth, or hemorrhage, or still-birth, or death-in-childbed.

Gerontocracy, Ancestor Worship are major elements of traditional social control in Togo, but equal to, and counterbalancing these is the weight of public opinion. In the face-to-face society, nothing is hidden. Where the maiden wears no clothes, the matrons will know her sexual status is altered. When the Elder supersedes the legitimate use of power, the Family deserts him, the Clan migrates. In togo, developing and influencing public opinion is a delicate art, and one which must balance information with due attention and respect to norms and values.

Traditional Social Structure: Feminine Role

It would be incorrect to try to discuss life-styles, and status and development of roles in universal terms for all of Togo, since social structures, and therefore human experience differ considerably from tribe to tribe and from clan to clan. But the general description given by Froelich ^{1/}of the position of women in the society could be very widely applied. The following are some excerpts from the translation done by the design team anthropologist.

"In the populations studied, the women is respected ... she is treated with regard, she tends more and more today to have a total freedom. In married life, the woman is rarely maltreated; one has even seen them beat their husbands.

"The first wife rules the household, she has superior rank; conflicts between wives are regulated by the Kpenya, the Chieftainess, who also directs the collective work of the dances.

"Kotokoli women are very volatile, and easily abandon husband and children, or demand divorce. Reasons presented are the sexual incapacity of the husband, or the absence of children after several years of cohabitation, because the cause of sterility is always attributed to the husband. Enjoying budgetary independence, the woman keeps for herself all her earnings, but she must buy the condiments, the firewood, the salt and the kerosene for the household cooking at her own expense.

"If she has cooked certain luxuries (croquettes made of bean-paste) she may sell them to her husband. For the preparation of their food, widowers and bachelors will give a payment in foodstuffs to the wife of a kinsman, or to a neighbor-woman.

"The widow of child-bearing age always remarries after forty days of mourning, either with a younger brother of her late husband, or outside the family; but in the latter case, the new husband will reimburse her dowry to the heirs. Old women are kept by a son or a

1/ Froelich, J.C., et al: Les Populations du Nort Togo, Presses Universitaires de France, Paris, 1963.

brother; they try to render themselves useful in small tasks. To have many children is the honor and the desire of women and of their husbands." ... 'The women without children will try to obtain them through the supernatural intermediary of a Leza (a sort of spirit of fecundity)", at least if her sterility is not due to a curse or spell put upon her, which can be revealed by the diviner ..." 2/

In general, women have been traditionally controlled by older patrilineal kinsmen, i.e., father, and father's male kin. This is particularly true regarding disposition in marriage. A woman's children (in most Togolese society) belong to her husband's family, at least if he has paid the bride-price that validates his claim to them. Cases are not unknown, through, where a girl of spirit has defied her family choice of mate, to marry the suitor of her own choice. In the country, this is still rare enough to occasion stories five years later!

There exist various authority roles for women in traditional society. Among these we may remark the predominant position of the first-wife in a household, and that of the father's sister who has considerable responsibility -- and receives special service and respect from the brother's children. This role is predominant especially among coastal people. There are older women, highly placed in Lineage and Clan, who hold ritual roles, and can sacrifice at certain shrines. Equally, young girls may be chosen to be trained as priestesses among certain groups, and such women should not be offended. They hold the dangerous power to pronounce a ritual curse. Some women learn to know "all the plants" (toutes les feuilles"), and become highly skilled guerisseuses. They may become midwives in the traditional scene, as well as knowing the combinations of plant-and-magic necessary to care for most physical and/or ritual-status ills.

Each woman in a polygamous household will seek to have children, because until she does, her place and her status are insecure. Further, since every marriage is ultimately supposed to forge a social-support link between two extended families, the birth of children to a union is necessary in order to confirm and maintain that link. The child's life is the validation of alliance. Woman's fecundity is social glue.

If a woman marries a second time, or more, it will still be necessary for her to produce children to the new union, especially if the new spouse is not her previous husband's lineage.

2/ Ibid

A young girl learns a woman's occupation (cooking, cleaning, carrying wood and water, caring for children, gardening, sowing and harvesting, making beer, buying and selling in the market ...) from the age of six or seven, when she begins to help her mother. In most groups in the north of Togo, the pubescent girl "when she begins to have breasts" will be taken with her agetates to the "bush-school". Here, isolated from normal village life for a period which may range from several months, she is taught the social and physical content of womanhood as defined in her society. At the end of this period she is ready to be betrothed, or if already promised, the bridegroom's family may prepare to claim her. Marriage may thus take place, depending on the given society, anywhere from age 15 onward. In some societies custom left a young girl sexuality at liberty for several years, and she proceeded to her fiance's house and conjugal status only when indubitably found-with-child. In others (ex. Lamba) she received her fiance in sexual visit quietly, at her parental home, and only joined his household when her pregnancy was well advanced.

Maternity and birth practices in Togo are extremely varied. In some groups, the mother is aided by her aunts, the women of her own family. In others, it will be older women of the husband's family who attended her. In some villages there are specific women who gain professional skills and are always called. Sometimes a woman is expected to give birth on her hands and knees. Elsewhere she sits. Often the cord is cut with a ritual knife. A baby may, de rigueur receive his name and destiny from the events of his birth and presentation. Again, he may receive no name, and no social personality until several months posterior to his birth. Among some peoples, a child and mother come out of the birth house on the 8th day; among others they may be required to remain within for 40 days. All that may be said with certainty is that variety is the rule, and practices are group-specific. But birth is a social, as well as a physical event, and all planning for social change must leave margins to accommodate the social side.

Attitudes Toward Family Planning

A pilot socio-demographic survey of the predominantly Ewe Maritime Region, the most populous and densely populated region in Togo, was carried out in 1969 by the Department of Sociology, University of Ghana. A total of 293 females, 15 years and over were interviewed. This survey was repeated later in all regions of Togo and the findings were very similar to those of the maritime region. The following paragraphs give some of the respondents views.

Who Wants Child Spacing

About 90% of the respondents would like to have their children spaced out, 8% would like theirs close together and 2% could not say how they wanted their children spaced out. In terms of family planning this finding is very significant whether or not the women studied did in actual fact have their children spaced out. The fact still remains that the will or the desire not to have children too close together exists among 9 out of 10 women interviewed. Any observed discrepancy between what these women say or wish on one hand and what they practice on the other hand may therefore be explained by the fact that the women did not know how to achieve the desired birth interval between their children; even where they do know these means, they lack the means to achieve this.

Ideas About Space Between Children

A majority of the women did not only want their children spaced out but 98% had definite ideas about the approximate number of years they want between their children. Thus 8% would like a space of 1 year between their children. 23% prefer 2 year-intervals while 50% or half the total number prefer 3 years. Another 17% would like to have their children at intervals of 4 years or more. Thus the desire of 90% of the women to have their children spaced out is further supported by the fact that 67% would insist on 3 or more years interval while another 23% on a 2 year-interval. With only 8% preferring 1 year interval between their births it could therefore be concluded that having children well spaced out at intervals not less than 3 years is the ideal form of child bearing majority of the women interviewed would want.

How Are These Ideas of Spacing of Children Put Into Practice?

In terms of family planning, it is not sufficient to know whether women would space out their children or not. It is equally important to find out how they do or attempt to achieve this: 20% or one out of 5 women interviewed would "do nothing about", "leave it to God or destiny" or "don't really know what to do". Here, therefore, is a group of women, at least 1 out of every 5 interviewed, who, although would like to space out their children at definite birth intervals around 3 years, have no idea about how to achieve this and therefore have to resign themselves to faith or destiny and rationalize the situation by saying "a child is a child and must be accepted as such" or that "a child being a gift of God should not be rejected", or the religiously faithful would say "It is God or destiny who decides on the interval between births". We thus have a group, at least 1/5 of our sample who are likely to be potential adopters of patent contraceptives (at least for spacing purposes) if they are taught to realize that although children are gifts of God or destiny, depending upon the individual's own resources, health and ability to cater for the children, a woman can decide when to have a child as well as when she has enough and wants to have no more.

However, 62% i.e. more than 3 out of every 5 women in our sample would either:

- (a) come to definite terms with their husbands, or
- (b) avoid their husband's sexual approaches, or
- (c) simply sleep elsewhere or move to their parents.

This means that 62% of the women adopt sexual abstinence to achieve the desired spacing interval between their children. One form of this, "coming to definite terms with husband" involves getting the spouse agreeing to the need and necessity for the wife not to have too many children at too close intervals. This presupposes full cooperation, sympathy and goodwill of the husband. But it is not always so since it is hardly the case in traditional West African societies that both the husband and the wife have equal say on matters of sex and children. Under such circumstances, such agreements between a husband and a wife on sexual abstinence are usually feasible when it is in the interest of the husband or where the husband is the one who recognizes the need to space children and therefore is ready to impose some sexual discipline on himself. However, this is not so and the reason is usually to be found in the following common expression of the women interviewed, "the men don't have to carry a pregnancy for 9 months". Thus, although, it is possible to come to such "entente" between husbands and wives (and some women, especially those who are strong, personalities -- wise, economically and psychologically -- do achieve this); another form of sexual abstinence is for the woman to "simply refuse or avoid husband's sexual approaches". This in fact is a drastic measure for a woman to take and she must be fully convinced about how she is going to take such a decision since such an action may lead to marital discord. Fortunately, such decisions are not taken in isolation but are usually combined with some sort of temporary physical separation of the spouses usually in the form of the wife simply moving to her own or the husband's parents. It is to be noted here that sexual abstinence in the combined form of avoiding a husband's sexual advances by simply moving away is in actual fact easier than it at first seems. This is because the practice of temporal physical separation of spouses is institutionally supported in the fact that Ewe women are usually encouraged to move away from their husbands either immediately after the birth of a young child and do not return till they are ready for another child or when there is a dispute which the woman considers serious enough to justify temporary separation pending reconciliation. We thus see that in addition to have specific ideas about the desired spacing intervals between their children, at least 62% of the women interviewed resort to sexual abstinence of different sorts in order to achieve the desired interval between their children.

Another method adopted to achieve the desired spacing between children which is the choice of 9% of the sample is sexual abstinence on the part of the women while either allowing or advising or condoning with the husband to satisfy his sexual desire elsewhere or (ii) advising the husband to take another wife, i.e., keeping a temporary sexual distance away from the husband. This solution, and to some extent the one discussed just before it, throw some light on traditional Ewe wife's attitude to polygamy. It is accepted as the lesser of two evils -- keeping a sexual distance from the husband but allowing him to satisfy himself elsewhere or being the only sexual partner and be exposed to the risk of unlimited pregnancy experiences.

However, with education of women and both husband and wife participating in wage labor, sexual abstinence on the part of the woman by her moving away to her parents will become almost impossible and less popular as a method of achieving desired spacing intervals between births because the woman's obligations will no longer be to her husband only but also to her employer. Illiterate housewives not in wage labor employment are able to utilize this method because they don't find themselves in the dual obligation situation as their educated counterparts in wage employment. Thus with increasing female education which necessarily leads to increasing female participation in the labor force, the proportion of wives who resort to physical separation from the husbands to achieve desired birth intervals between successive children is likely to reduce drastically. This is not due to education per se but to the consequences of education. Conditions of employment will not allow them to go away to their parents for unlimited periods and the difficulty of obtaining housing in the urban areas is likely to compel this category of women to continue sharing the same housing facilities with their husbands. Patent contraceptives are likely to appeal much more to this category of women than physical separation. This may account not only for the observed higher incidence of patent contraception usage among educated women in West Africa but also for the reluctance of this category of women to condone polygamous marital relations.

The results of this survey throw doubts on many ideas and views held about attitudes of rural women to family planning. These findings show that rural women are not as conservative as they are usually pictured; that the basic problem is that of IGNORANCE of the means, possibilities, potentials and medical as well as health soundness of hazards of family planning methods and techniques. The rural woman is willing to have access to family planning techniques and may be willing to adopt these whole-heartedly provided she is approached in the right manner.

Motivation

Effects of Too Many Children at too Short Intervals On:

a) Mothers:

Whether the women interviewed do space their children out or have them too close together, one thing came out clearly in this survey; 87% of those interviewed for different reasons clearly recognize the adverse effects of unlimited births on mothers; 9% felt there need not be any effect, even here they usually qualified their statement by saying "what matters is that the mothers should be in good health". In actual fact, only 4% did not seem to know of any effects or were not certain what the effects are.

Concerning the specific nature of the effects of rapid succession of births at too close intervals on mothers, more than 4/5, i.e. 84% saw the ill effects in terms of the mother's health: 11% saw the effects in economic and financial terms with emphasis on mother's inability to give adequate support to the children. Another 11% felt that such situation often led to psychological and emotional unhappiness of the mother.

b) Children:

Such adverse consequences of lack of suitable spacing between children are equally seen to affect children as well; while only 3% of the women did not seem to know what the effects might be on their children, 6% find no effects. A majority of them felt the effects were as adverse on mothers as on children. To 19% lack of suitable spacing between births makes it difficult for parents to provide adequately, educationally and financially for the children; 72% however saw the effects of lack of suitable spacing of children in two but highly related factors:

- i. In terms of the health of the child which may also lead to the possible death of the first child, as well as
- ii. in terms of nutritional deficiency leading to koshiokor.

Although the women fully recognize the ill effects of lack of suitable birth intervals between their children, it is equally clear from the methods of spacing children described earlier that these women cannot really succeed in keeping the desired interval between their children without definite hardships and inconveniences in the form of self imposed sexual abstinence by physical break between spouses, whereas the same ends could have been achieved (perhaps more efficiently) by using patent contraceptives without these self imposed hardships. Thus, in such situations as these, the length women are willing to impose such hardships on themselves can be a reliable indication of not only their recognition of the need to space their births, or even to limit the number of children but also of an indication of the extent to which they are willing to put this into practice

Minimum Participator Profile

The minimum participator is a female resident of Togo. She is illiterate and her experiences are most likely limited to the strong influences of her rural environment. She is married and thus exposed to a high risk of becoming pregnant as marriage in a rural West African environment necessarily implies child bearing. Her profession is housewife/farmer or possibly housewife/trader. She is greatly influenced by traditional religion. This may be explained by the high illiteracy rate among the population since there is a strong correlation between illiteracy and adherence to traditional religion in Togo.

There is also a strong correlation between literacy and acceptance of modern family planning methods. This is true not only in Togo but is supported by experience from most developing countries in which family planning services have been made available and are within reach of the poor, illiterate rural population. Nevertheless, experience - for example from Indonesia - has also shown that the slow acceptance of illiterate women of family planning can be overcome, regardless of traditional or religious beliefs, when motivation and education of the population are approached tactfully and in a way that does not offend the population's moral conviction.

As noted in the revised Health Sector Assessment, a large portion of Togo's upper echelon medical personnel is

located in the capital city of Lome. The least trained personnel in the health system are those dispensing most of the medical care to most a major portion of the rural population. It is useful to view candidly some of the factors involved in this very hierarchical distribution. Professional roles within the modern sector are also high status (and high return) roles in the society. Entry into them is most accessible to individuals coming from existing upper-class (socio-economic and/or political) positions. But for this elite, career development necessitates presence in Lome. As in so many centralized states, the capital tends to impoverish the rural areas. Assignments to a rural post are predicated on a five-year tour of duty. But five years is a long sojourn away from Lome. Equally, families present problems - wives may be unwilling to stay in the limited rural situation, and schooling for children may be less than adequate to elite standards. Thirdly, continued learning and/or research possibilities are viewed as difficult, if not impossible in a rural post. Some of these problems might be solved with a system of more frequent rotations. Development of up-country advanced centers and general development might also assist. But in the final analysis, only self-regulation by the discipline and profession themselves, as well as tightly defined administrative requirements are going to address this problem.

The Togolese Health Plan envisages a hierarchical structure of responsibility and command. In practice, this command structure operates in a very traditional way: i.e., it differentiates a set of unequal statuses within the health system, and designates the personnel who are to occupy each niche. It also defines more or less the entry requirements into each position, and the type work to be addressed by the incumbent. But the relationship between dominant and inferior roles is in the nature of a statement of, and recognition of authority, rather than supervisory, educative, and corrective. Often there seems recognition of inequality, but very little control is exercised. This is a type of social interaction pattern inherent in societies where status is conferred by birth, and there is little mobility. Such relations are more defined by the existence of inequality than by a dynamic upward and downward flow of goal-orientated communication.

Constraints

At the social interface between tradition and

modernity lies a gray area of differences in perception and usage. An example of this might be the use of penicillin shorts to manage venereal disease, or immunization shorts for measles. For the traditional viewpoint, these are medicines, therefore they are of themselves powerful (supernatural power). One must use them following the appropriate ritual and that they will be effective. The medicine of itself is a seat of power. The modern-sector Togolese Assistant Medical, or Pharmacist or Aide Technician is aware that, in the employ of these chemicals, the right dosages at the right intervals are necessary. They are despairing when the venereal disease patient develops a resistant strain: a little penicillin, but not enough to cure. The child gets his first measles shot, but never develops immunity because the series were not completed.

Use of existing health facilities is very uneven, and some are grossly underused. Various reasons can be adduced:

Most clinics are visited in the mornings, but in the afternoons the clinic personnel are often underoccupied, and the dispensaries almost empty. This can to some extent be accounted to the women's time-use patterns, and to their sets of obligations. A rural woman's life is hard: there is water to fetch, wood to carry, food to cook, gardening to be done, and visiting patterns occupy early morning hours.

In some instances, the quality of services offered in the clinics may be low, or the personalities of staff ineffectual. In general, it must be emphasized that staff seemed accessible and devoted.

Modern health facilities constitute a parallel system, seeking to replace old institutions that addressed the problems of health and health care. Often rural people need to be inducted into the use of the new system; they must learn what they are, how they work, what they can offer. This problem is very intelligently approached in Togo, when Social Affairs personnel initiate conferences at the village level, and seek to bring the villagers to discuss and develop plans to handle their own problems, envisaged broadly. This initiative is echoed in the efforts of the Organisation pour le Bien-Etre Familiale. A fundamental approach to this problem is the Health Education Program now being developed in Togolese schools.

A last point to consider with regard to use of maternities lies in the fact that giving birth at a Health facility, instead of at home, amputates the social side of

birth, which is, after all, one of the great moments in Life, the First Passage. Traditional attendants and attendance, ritual, beliefs -- all have difficulty attending a dispensary birth.

A point which must be borne in mind is that there is, and will remain for the foreseeable future a differential access among Togolese to all valued goods and services, and this includes health-care. There are better and worse facilities, and sometimes no facilities. Some people may have too far to go to make it feasible.

Ideally, we must also consider those who may be threatened by the implantation of new institutions, methods, ideas. In looking at the Togolese projects for family health care, threatened roles seem to be those of the traditional midwife, customarily a responsible and devoted woman, who worked "between life and death" to save the lives of women and their babies. It would be useful to see as many as possible incorporated into modern training for accoucheuses auxilliaires.

In the world before-the-Coming-of-Modern Medicine, medicine was what was mostly delivered by the Guerisseur. These traditional herbalists often know a great lore of plants and curatives. Much of their knowledge may still have real value today. Research into traditional medicine and attempts to incorporate traditional healers into modern Health Planning could avoid a waste both of knowledge and of people.

Communication Strategies

Both television and particularly radio as a means of mass communication in Togo offer the potential for assuming an increasing role in communicating family planning and other health care information. The DAP states about 70% of the heads of households listens regularly to radio news. Also, several radio and T.V. programs on family health, health education, sex education, nutrition, etc. have already been broadcast.

Family planning will also be introduced to mothers by the Itinerant Agents before they are confronted with the necessity of making decisions in a clinical setting. These Itinerant Agents will be able to put family planning in the cultural context of the people living in the area where they are working. When they identify a woman with a particular risk who should not become pregnant for some time, they will explain the services offered by the MCH centers.

This also applies to auxiliary midwives as they play an important role in the establishment of primary contacts and care of rural women. Since they usually live and work in the region or district from which they were originally chosen for training, they will be in a better position to integrate new standards and practices with the supportive cultural mores associated with birth in the particular ethnic groups.

Spread Effects. The Diffusion of Innovation

As defined by this project the phrase "family health" or "family well-being" is somewhat dichotomous. The health or well-being of a family suggests the inclusion of all members of the family regardless of age and sex, but the actual target groups of this project are limited to women in reproductive age (15-44) and children in the 0-5 years age group. With an estimated population in Togo of 2.5 million in mid-year 1977 there are about 525,000 women (21% of the population) in that age group, and an equal number of children under five years of age. These two groups - representing 42% of the population - will be the primary beneficiary of the project. They will receive the bulk of family health services: prenatal and post-natal care, family planning services, nutrition education and control of nutritional status, immunizations against communicable diseases, pediatric consultations, etc. Indirectly, however, the whole family unit will benefit from improved family health.

The school age children will learn about sex education in the schools. The husband will both socially and economically benefit from the child spacing services provided for his wife (or for himself, if he chooses to use condoms); and better sanitation, control of communicable diseases, etc. will benefit all members of the family. Thus the nation as a whole should ultimately directly or indirectly benefit from the training programs and health educational services provided for by this project.

As described in the foregoing, the outreach or spread effect of the project depends on the actual performance of the students at the Center when they return to their posts. With about 135 students returning each year after having received in-depth training in family health and a conservative estimate of each of the returned health personnel consulting or treating 10-15 patients per working day, the combined effects of the project would mean some 400-500,000 family health consultations or services provided by first year students; this number will double the next year, triple the third year, etc.

However, the total number of consultations or services provided gives only a rough idea of the benefits expected from the project. The percentage of women and children who will ultimately benefit from improved family health services is more important. The Health Sector Assessment pg. 25: Antenatal, postnatal and maternity practices, shows that 70% of the rural population live within a distance of 10 km. from the nearest health facility; that 75% of the women prefer professional health personnel to assist at their deliveries and that more than 90% of the mothers interviewed at the survey would seek medical care for their children when they were sick. These figures are strong indicators that the great majority of the target groups will benefit from improved maternal and child health services.

While the above may indicate the possible spread effect of the project the question about "the diffusion of innovation" has not been fully answered. The introduction of family planning as a means of child spacing is one of the most important innovations of the project. There are several factors determining acceptance of family planning services. Foremost among these are: (1) easy access to services; (2) the quality of the services provided, and (3) the motivation of the population to accept family planning.

As stated earlier, family planning services will be immediately available in at least one MCH Center in each health district. However, as the number of trained personnel and of health centers providing family planning services increases each year there should be easy access to family planning services for about 70% of the rural population within the next five years. The quality of services are important because the satisfied acceptor of family planning is the best motivator of her neighbors. The word will spread quickly in rural Togo, and a few clumsily done IUD insertions, or a few unexpected complications from "the pill" can easily spoil or delay a family planning program for years. As mentioned earlier, the motivation for child spacing is extremely high among the rural women in Togo and with well organized mass educational programs; training of auxiliary midwives, social workers, and agents itinerants to further educate and motivate people to accept family planning the basis for an extensive family planning program will exist in Togo. Nevertheless, experience has shown that acceptance of family planning by an illiterate, poor rural population takes time. Therefore, a reasonable - but still rather ambitious - target would be that ten percent of married couples - or approximately 40-50,000 women or couples will utilize a modern contraceptive method within the next five years of full operation of the Center (i.e.,

end of FY 1985)

Leadership/Authority

There are several groups in Togo whose leadership will be crucial for the success of this project. On the governmental level the MOH and the Ministry of Education are the two most important agencies in regard to promoting the concepts of family health including family planning and sex education. The two ministries have already demonstrated their capacity for leadership by drafting the National Family Health Plan; providing short courses in family health for health personnel and social workers; and by introducing sex education in the schools. Also the Ministry of Information has shown interest in this endeavor and has offered program coverage in its women's program. From a somewhat controversial issue, only a few years ago the concepts of family health now receive full and open support on the ministerial levels. This is evidenced by the frank discussions on family health in mass media and seminars attended by high ranking governmental officials. Another interesting and possible significant development is that the MOH now has added "Promotion Feminine" to its title. A Secretary of State has been attached to the Ministry to promote the role of women in the society, their participation in all aspects of socio-economic development and in decision making. She feels strongly that a first step in this direction will be to enable the women to space the births of their children in accordance with their desire. The GOT is aware of the resistance to change on the part of many of the older and conservative leaders in the population and is aiming the major part of its educational efforts at the youth.

The governmental efforts are strongly supported by two voluntary agencies: The National Family Planning Association, which recently changed its name to Association Togolaise pour le Bien Etre Familiale, and the Togolese Women's Association (UNFI). Both associations have been officially established by governmental decree and have, since their inception, played a leadership role in preparing the way for governmental action. The Association pour le Bien Etre Familiale is now in the process of establishing local chapters in all regions. Its aim is to assist the MOH in establishing and conducting family planning clinics in all districts as rapidly as possible. Thus the Association does not want to compete with governmental health services but rather to

supplement governmental efforts in promoting family health wherever possible. The Association has expressed its high interest in and full support to this project, and officials of the Association have participated in meetings with GOT and AID officials during the development of the project.

The leadership role of governmental and voluntary agencies is thus well established and assured. However, the leadership role assumed at the local or village level will be of equal or even more importance for the successful implementation of the project. Who will be the leaders may vary from region to region, from district to district, and even from village to village depending on traditions and personalities of the different tribes and their leaders. It will be an important part of their duties for the different social workers, auxiliary midwives and agents itinerants to recognize the potential leaders in their areas and work closely together with them for the mutual goal of improving health and life in the village.

Due to their mobility the agents itinerants may play a special role in this respect. The itinerant health personnel will visit all households in their area once a month and are used to work closely with the village health councils where they exist, or with the village chiefs and other village leaders. Thus they can contribute substantially to bridge any existing gaps between the village leadership and the governmental leadership and provide the link between the village population and the governmental health services.

Maximum Information and Resource Distances

The mean distance to the nearest hospital/clinic is about 9 kms. from a health facility. Asked about how to get there, more than 99% of the women said: by foot, and about 60% said it was easy to get there while the remaining found it somewhat difficult; but only a few percent said they had never been there. Forty percent of the women stated that they visited the hospital/clinic often and an equal 40% said they visited it rarely; and an additional 12% said, "only when indisposed."

Asked about if they were well received at the hospital/clinic, the countrywide response was 82% answering yes. In the Savanna as many as 95% of the women interrogated were satisfied with the reception they received in the

hospital or clinic.

The above data shows an almost unheard of degree of confidence in and satisfaction with governmental rural health service. The personnel who carried out the survey were well warned against the tendency of the respondents to be "nice and positive" when asked about governmental service. They were instructed to win the confidence of the women and explain to them that they could be frank in their replies which would be kept anonymous. But, nevertheless, only a few women complained about long waiting time, poor treatment by or poor attitudes of health personnel.

Social Consequences

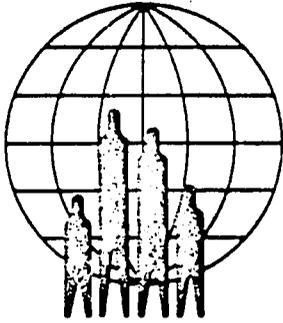
Social Consequences of this Health Project, with the extended delivery of generalized better health care to mothers and children, should be a measurable decline in rates of morbidity and mortality in these target groups. One can anticipate a far more rewarding life for children who will not have to carry around the burden of disease which may be eradicated.

Balanced against this happy vignette, it is prudent to consider ecological ratio of population to land-support-potential. To the north of Togo, the Savannah penneplains are fragile lands. Even if they can be made to produce more, they are easy to exhaust. Need for too much firewood strips the land of trees, and the desert encroaches where the trees are cut. With a hard crystalline rock sub-strata, water is not easy to obtain in Togo, and the water-tables must be able to bear the population load. This is already a land where only a small loss of expected rainfall moves the balance from food marginality to famine. And meteorological long-range prediction envisages the current long-range trends as increasing and cyclical regional drought.

The specter of Malthus insists that Togo -- expected to double its existing population in the next 26 years -- must not only plan for health, but plan for quality of life, and quality and quantity of life-support system. Thus it is hoped that the project's emphasis on child spacing besides its obvious social benefits also will help to slow down the high population growth rate which threatens the equilibrium of family life.

Rural Displacement, Migration and Urbanization

There are presently about 20 families living on the proposed Center site. They are squatters and have been notified by GOT officials that they will have to move. The GOT has agreed to assist these families to relocate. This problem will be addressed during negotiations of the Project Agreement.



-143-

ANNEX M

Family Planning International Assistance

THE INTERNATIONAL DIVISION OF PLANNED PARENTHOOD FEDERATION OF AMERICA, INC.

LEONARD H. ROBINSON, JR.
REGIONAL REPRESENTATIVE
AFRICA

July 13, 1977.

Mrs. Sally Sharp
AID Affairs Officer
American Embassy
Lome, Togo.

Dear Sally:

Apologies for the late arrival of this letter, but as I'm sure you can imagine the situation has been rather hectic here!

Pursuant to our discussions last week with Dr. Poulson, Sid Chambers, Jay Johnson and Dr. Placca, FPIA Africa will proceed to draft a project proposal for financial and material assistance to the Ministry of Health and Social Affairs -- for the training of medical/health personnel in MCH/family planning service delivery and IEC activities. Total projected costs for project year one estimated at \$145,000. In reworking the budget, this figure may be adjusted up or down.

Although I feel comfortable and assured with Dr. Placca, as well as the various AID Togo, Abidjan and Niamey inputs/support, it should be understood that FPIA proposes to provide assistance to the above delineated project. Final approval must be obtained through normal procedures which entails FPIA New York and AID/Washington. I hope to have the draft prepared prior to my departure for New York; copies will be sent via the pouch.

Thanks for the warm hospitality last week. I shall miss the close proximity, but look forward to numerous periodic visits from "safari" country,

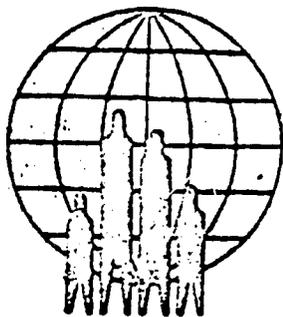
Best regards to Max!

Sincerely,

LEONARD ROBINSON, JR.
Africa Regional Representative

POST OFFICE BOX M. 387, ACCRA GHANA

Telephone Number: 27118 CABLE: FAMLIPLAN/ACCRA, GHANA



Family Planning International Assistance

THE INTERNATIONAL DIVISION OF PLANNED PARENTHOOD FEDERATION OF AMERICA, INC.

LEONARD H. ROBINSON, JR.
REGIONAL REPRESENTATIVE
AFRICA



Mrs. Sally Sharpe
AID Officer
USAID Mission to Togo
American Embassy
Lome, Togo

Dear Sally,

I have reviewed the draft document outlining structure and proposed activities under the "Togo Family Health Project". Basically, I am in complete agreement with action-oriented objectives projected for the National Family Health Center, in particular, training of nurses, mid-wives in maternal/child health and family planning service delivery (MCH/FP), and field educators/motivators in MCH/FP information/education techniques.

The Togo situation in terms of political/social sensitivity to family planning per se, is roughly analagous to what prevailed in Ethiopia three years ago: interest on the part of private and some government officials for the provision of MCH/FP services, especially in rural areas, but a reluctance to initiate activities "officially" for fear of repercussions, those based upon religious, cultural/traditional beliefs, or those politically motivated. Nonetheless, steps were taken and today family planning is wide-spread in Ethiopia, this despite the absence of an official policy or government's "public" recognition.

If I may, I'd like to draw heavily upon the Ethiopia experience in assisting your efforts in Togo. First of all, let me hasten to state that the establishment of a "Health and Family Welfare Center" where physicians, health officers and nurses were trained by Ethiopian personnel, was absolutely key to the project's credibility and acceptance. I note from the draft proposal that training will serve as the nucleus of activities conducted at the national center.

Prior to the development of the Ethiopia center, services were provided minimally, usually in urban areas; practically nothing was available in rural areas. Although there was strong interest in expanding services to rural inhabitants, caution was exercised due to a lack of trained personnel. I encouraged the local family planning association (IPPF affiliated) to consider setting up its

own training program because (1) two of their nursing sisters had undergone training in MCH/FP at the Downstate Medical Center in Brooklyn and were qualified as tutors; (2) the association had a well qualified gynecologist who worked and taught in several family planning clinics throughout Africa, and (3) because Addis Ababa had a number of resident experts/professors in the fields of preventive medicine, community health, maternal and child health care, nutrition, demography, etc. who could be used as consultant lecturers to augment the core training staff. This combination of factors proved highly successful, to the extent that in two years over 165 health personnel have been trained in MCH/FP, and service delivery points increased from 26 in 1975 to 170 by the end of 1976. Likewise, there has been a ten-fold increase in family planning acceptors, primarily in rural Ethiopia.

Togo lends itself to a duplicative effort. I'll briefly outline how it could be set-up.

Core Training Staff

Total staff size depends upon how many trainees per training cycle will be enrolled. Assuming no more than 20 per cycle, (more than 20 could be cumbersome and disruptive to training. Individual consultation/ATTENTION key element in small training program. Also, larger group would jeopardize practical work in Lomé based clinics, which are probably few in number) the following staff alignment is suggested:

- Training Director (could double as center director)
- Medical Advisor - PART TIME
- Nurse Tutors - (3)
- Information/Education/Communications Co-ordinator
- Field Educator/Co-ordinator
- Consultants from University of Togo and Health Nutrition/Family Planning related institutions.

All these people should be trained and experienced in their respective areas. Nurse tutors would carry the bulk of daily activities/responsibilities and should have tireless energy/enthusiasm. The draft indicates that some personnel have already been trained abroad. If so, they should be recruited and hired for the center, and enrolled to an in-service refresher course. This could be provided through FFIA's training project in Addis Ababa or through the Margaret Sanger Bureau in New York, just to mention a few.

To the extent feasible, I highly recommend that all core staff be Togolese. This would negate possible charges of it being an "American" program and accelerate acceptability of a new concept in family health practice/care. I also think it would enhance receptivity by the Ministry of Health. If the project is totally funded by AID, a U.S. project manager as noted in the draft may be mandatory. If so, he/she should sit in the AID office, not the center. If the training segment is funded by FPIA, we would monitor and provide technical assistance on a periodic basis through the training director and from FPIA's regional office. None of our projects have an American "in residence".

Training Cycle/Structure

Six training cycles per year or one every other month, are ideal. By allowing a month in between cycles, you can adequately plan, alter the training pattern/curriculum and provide crucial follow-up supervision and technical assistance to graduates working in the field. Follow-up is especially important within two months of a trainee graduating from the center: it provides instant feedback on whether or not graduates are utilizing their skills through the provision of MCH/FP services; allows follow-up staff to provide technical assistance where required, and offers an opportunity to reinforce everything taught in training.

Curative medicine is practiced 95% of time in most developing countries, therefore, the strain on existant medical and health personnel is tremendous. With this being the case in Ethiopia we opted for a one month training cycle. This period of absence away from hospitals, clinics and health posts was acceptable to the Ministry of Public Health and especially to hospital and clinic supervisors in the field. In one month, intently train people in MCH/FP service delivery.

Training Curriculum (Knowledge to be Acquired)

Relationship between MCH and Family Planning

Methods of Family Planning:

- a. Oral contraceptives
- b. Intrauterine devices
- c. Sterilization - Male and Female
- d. Condoms.
- e. Foams/Jellies
- f. Natural methods

(Indications, contraindications, complications and side effects follow-up and referral systems).

3. Fertility and Sub-Fertility (the latter sometimes referred to as infertility - a serious problem in West Africa)
4. Maternal Health
 - a. Pelvic anatomy and physiology
 - b. Ante-natal care - selection of high risk patients
 - c. Vaginal examinations - abnormal findings
 - d. Vaginal discharge and treatment
5. Reasons for High Infant Mortality in Togo
 - a. Lack of vaccinations
 - b. Ineffective health education at home
 - c. Poor nutrition
 - d. Compact birth
 - e. Infection
6. The quality of life as it relates to the health, social and economic aspects of family planning.
7. Maternal and child health/family planning information and education.
8. Organization of a MCH/FP clinic.
 - a. Maintenance of equipment and supplies
 - b. Record keeping/statistics
 - c. Establishment of clinic hours.
 - d. Patient referral and follow-up system
 - e. Logistics.

Skills to be Acquired in Training Program

1. Rapport with patients - counselling - education
2. Medical examination, including:
 - a. Cardio-vascular system (blood pressure recording)
 - b. Breasts
 - c. Legs - for varicose veins
 - d. Pelvic
 - e. Speculum examination

Invitations to train should be initiated through the Ministry of Health. This lends legitimacy and credibility to the program immediately.

Periodic Self-Evaluation. Trainees Assessments

Trainee skills/knowledge should be measured before and after each training cycle. Contingent upon the overall knowledge of a given group of trainees, content can be adjusted to allow for additional inputs and/or deletions. Likewise, content can be adjusted at the end of each cycle to accommodate changes/alterations recommended by core staff and trainees themselves. The curriculum should maintain a degree of flexibility at all times.

2. Trainees should assess the program before graduation. This is a valuable source of feedback with respect to content and training personnel. In Ethiopia, trainees are allowed to evaluate the program each week, including consultant lecturers. The result is a finely tuned program.
3. See Exhibit D for pre and post training knowledge questionnaire. Pages 3-6 are repeated at the end of training to provide a comparison between pre and post scores.
4. See Exhibit E for a post training evaluation questionnaire.
5. See Exhibit F for graduating certificate.

Supplies and Equipment

Rural based hospital and clinics are often inadequately stocked to administer basic health care. At the end of each training session, graduates should be given sufficient supplies/equipment for three to six months of MCH/FP activity, including:

- a. Contraceptives all types
- b. IUD insertion kits
- c. Instrument sterilization equipment
- d. Antiseptic solution
- e. MCH pharmaceuticals and antibiotics
- f. Resource books and audio-visual aids.

MCH supplies are critical, otherwise the program will be vulnerable to charges of being slanted heavily towards family planning, especially from trainees.

Budget

FPIA could fund the entire MCH/FP training section for 3 to 5 years, including staff salaries, other direct costs, vehicle maintenance and gas, etc. Actual figures can be worked out in conjunction with Togo Government and AID officials. This has become unduly long, but probably necessary to set items out clearly. I look forward to putting this into a workable plan of action.

Sincerely yours,

LEONARD H. ROBINSON JR.
Regional Representative Africa