

PD ARH-872

APPENDIX 3A, Attachment 1
Chapter 3, Handbook 3 (IM 3.43) *Elmh*

86500

Final

AGENCY FOR INTERNATIONAL DEVELOPMENT
PROJECT DATA SHEET

1. TRANSACTION CODE A B C D
A = Add
B = Amend
C = Change
D = Delete

Amendment Number _____ DOCUMENT CODE **3**

COUNTRY/ENTITY TOGO

3. PROJECT NUMBER **693-0234**

4. BUREAU/OFFICE AFRICA 06 3. PROJECT TITLE (maximum 40 characters) **Togo Child Survival and Population**

6. PROJECT ASSISTANCE COMPLETION DATE (PACD) MM DD YY **01 9 1997**

7. ESTIMATED DATE OF OBLIGATION (Under "B" below, enter 1, 2, 3, or 4)
A. Initial FY **91** B. Quarter C. Final FY **95**

8. COSTS (\$000 OR EQUIVALENT \$1 =)

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)	(3,762)	(0)	(3,762)	(15,526)	(0)	(15,526)
(Loan)	(0)	(0)	(0)	(0)	(0)	(0)
Other U.S. 1.						
U.S. 2.						
Host Country					5,544	5,544
Other Donor(s)						
TOTALS	3,762	0	3,762	15,526	5,544	21,070

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) DFA	400	450		0	0	3,762	0	15,526	0
(2)									
(3)									
(4)									
TOTALS				0	0	3,762	0	15,526	0

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)
420 430 450 530 562

11. SECONDARY PURPOSE CODE

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)
A. Code TRG BRW CS PVO
B. Amount

13. PROJECT PURPOSE (maximum 480 characters)
To improve delivery of Family Planning and Maternal and Child Health services, so as to increase contraceptive prevalence and Maternal and Child Survival.

14. SCHEDULED EVALUATIONS
Interim MM YY **01 9 1993** **01 9 1995** Final MM YY **01 9 1997**

15. SOURCE/ORIGIN OF GOODS AND SERVICES
 000 941 Local Other (Specify) **935**

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a _____ page / P. Amendment)

17. APPROVED BY
Signature *Sarah Clark*
Title **Sarah CLARK**
AID Representative to TOGO
Date Signed MM DD YY **10 31 1991**

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION
MM DD YY

REDSO/WCA/ Controller concurrence per
Abidjan **17029** Dated **September 27, 1991**

30 SEP. 1991

ACTION MEMORANDUM FOR THE AID REPRESENTATIVE TO TOGO

FROM:  Paul G. Ehmer, Health and Population Officer

SUBJECT: Togo Child Survival and Population Project (693-0234)

I. PROBLEM:

Your approval is requested to (1) approve the Togo Child Survival and Population (TCSP) Project Paper and, (2) authorize a grant of \$15.526 million from the Development Fund for Africa (DFA) appropriation for the TCSP Project. The planned FY 1991 obligation is \$3,762,000.

II. BACKGROUND:

Office of the AID Representative to Togo (OAR) Strategy:

Since 1987 OAR's strategy has included a focus on child survival and family planning. This complements the Mission's initiatives in encouraging increased agricultural productivity and rural credit, and its recent efforts to support the private sector. With the final development of the Country Program Strategic Plan (CPSP) now to be completed early in FY 1992, OAR will continue its child survival emphasis. Within the health sector, OAR strategy will focus on sustainability and institutional reform, and a strengthening of the private sector delivery of health services. The proposed project is based on USAID's current health and population portfolio, and builds on the achievements and lessons learned from this experience, as well as that of other donors in the sector.

Government of Togo (GOT) Policy:

The GOT is committed to the provision of adequate health and family planning services to the population of Togo, and with the assistance of the World Bank has begun restructuring the Ministry of Health and Population (MOHP) in order to improve service delivery. The MOHP has made major efforts to expand service delivery throughout Togo, and with WHO, UNICEF, and A.I.D. support recently has significantly improved immunization coverage and reoriented the malaria program's treatment policy to respond to changing conditions.

Health Status:

Over the past 15 years, the infant mortality rate has been cut approximately in half; improvements in recording and reporting epidemiological data have occurred; and Togo has approximately doubled the ratio of doctors and nurses in relation to the number of people served.

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In spite of this progress, maternal and child morbidity and mortality, and high population growth remain significant public health problems in Togo. Infant mortality is estimated at 80 per thousand live births, while child mortality (0-4 yrs) is estimated at 158/1000. Malaria and other infectious diseases, including diarrhea are the major causes of death. Low nutrition and anemia significantly contribute to both maternal and child morbidity and mortality. Population growth is estimated to be 2.9 percent, with a birth rate of 45 per thousand live births. In 1988, only three per cent of Togolese women were using modern contraceptive methods, but nearly 90 per cent knew of at least one contraceptive method. Private sector health and family planning service delivery is minimal outside of Lome.

Constraints:

Adequate public health infrastructure exists to enable the delivery of health and family planning services, but is constrained by three main factors: 1) insufficient coordination and integration of donor assistance into MOHP routine systems; 2) insufficient MOHP capacity to plan, manage and coordinate a decentralized program of health service delivery, and 3) the lack of encouragement and resources to enable the private sector to play a stronger part in health service delivery to all segments of the population.

III. PROJECT DESCRIPTION:

Objectives:

The goal of the project is to increase life expectancy and reduce the population growth rate, leading to an improvement in the health status of the population of Togo. The purpose of the project is to improve delivery of family planning and maternal and child health services so as to increase contraceptive prevalence and maternal and child survival. At the end of the project, the following improvements will be achieved:

- (a) The MOHP Directorates of Planning and Staff Training, and Finance and Administration will be staffed and functioning effectively. They will be providing adequate planning, budgeting, personnel management and staff development services, and logistical support to ensure the delivery of efficient and sustainable health services to the Togolese population;
- (b) MOHP service delivery programs will be integrated at all levels, and functioning efficiently;
- (c) Community participation in health and family planning service delivery will be established and functioning;

(d) Cost recovery programs will be in place and functioning adequately in all communities with public health facilities;

(e) Private sector delivery of health and family planning services will be increased, especially in areas outside of Lome; and

(f) Collaboration between the MOHP and private service providers will be increased.

Project Components:

The project has four interrelated components briefly described below:

COMPONENT ONE: Improving MOHP Management, and Expanding the Public Sector Health and Family Planning Cost Recovery Program

The improved management of the MOHP will comprise the following:

- (a) establishing a functioning Directorate of Planning and Training;
- (b) improving the Directorate of Finance and Administration's capabilities to provide personnel management, financial services, and logistical support;
- (c) assisting the Prefectoral Chief Medical Officers to better manage their resources and supervise the health facilities within their prefectures;
- (d) simplifying and integrating the existing health statistics and management information systems, while improving local health facility staff ability to plan and manage their own resources; and
- (e) developing MOHP capabilities to distribute essential drugs and medical supplies to all levels.

The process of achieving the project purpose requires that the MOHP develop a clear, shared definition of policy for the sector, clear standards and guidelines for management and service delivery, and a comprehensive management information system (MIS). This will include the development of an improved, integrated monthly reporting system for all health facilities. The development of the MIS and well articulated policies and professional standards and guidelines will strengthen decentralized decision-making and supervision, and promote coordination within the MOHP. These efforts in turn, will enhance the delivery of child survival, maternal health and family planning services.

This project component will support changes in the Statistical Division of the MOHP, enabling it to serve as the central source for data collected by the MIS. Also, the project will

help the Staff Training Division develop a system for coordination of training programs proposed by other Directorates, as well as maintain a record system for tracking MOHP personnel benefiting from medical, technical and management training. The Staff Training division will work with the National Health Education Service (SNES) to refine existing curricula, and develop training materials on the monthly reporting system to be developed with project assistance. Finally, a cost recovery system for the public sector will be developed with project assistance.

COMPONENT TWO: Strengthening Integrated and Decentralized Health and Family Planning Service Delivery

The second project component will address the integration and decentralization of programs at the level of training, management, supervision, logistics, and service delivery. This will be accomplished by developing various levels of integration. The first level will be the creation of multi-purpose prefectural public health teams headed by the chief medical officers. These teams will:

- a) provide medical and technical expertise for all MOHP program interventions;
- b) train health staff in all interventions;
- c) supervise all interventions; and
- d) manage all interventions.

Integrated training modules for program interventions and use of the revised MIS will be produced under this component. Finally, technical reference guides for service delivery, administrative operations manuals, and integrated supervisory protocols will all be developed over the life of project.

COMPONENT THREE: Promoting Public and Private Sector Collaboration in Health and Family Planning

This component will improve MOHP capacity to set appropriate quality control and professional standards, and to increase collaboration with private sector health service providers. Specifically, project resources will be used to develop the MOHP's capacity to monitor, set standards, and provide technical extension services to private practitioners, community health cooperatives, laboratories and pharmaceutical vendors.

COMPONENT FOUR: Expanding and Strengthening Private Sector Health and Family Planning Service Delivery

This component will expand private sector health care and family planning service delivery. It will assist in the development of professional associations for various categories of health professionals, and will make loan funds available to encourage private sector personnel who meet appropriate criteria to open offices outside of Lome.

Inputs:

Overall project inputs will include 288 person months of long term technical assistance, 37 person months of short term assistance, buy-ins from ongoing health and population central projects such as SEATS, SOMARC, Options, INTRAH, and Mother. Care; PASA arrangements with CDC; operational research and studies; commodities (including contraceptives); evaluation; financial reviews; and audit.

Beneficiaries:

The project will create a framework through which efficient and cost effective health and family planning services can be delivered by the MOHP and the private sector. The initial beneficiaries are the staff of the MOHP, who will be trained both on the job and in long- and short-term training, and the private sector health service providers who will benefit from the receipt of project loans to begin their private practices outside of Lome. The ultimate beneficiaries are the 750,000 women of reproductive age and 600,000 (0-4 years) children, who will receive integrated and comprehensive health and family planning services.

IV. ANALYSES AND STATUTORY REQUIREMENTS:

Analyses of the technical, institutional, financial, economic, and social aspects of the project were conducted during the preparation of the Project Paper. These analyses found the project to be institutionally, financially, socially, economically, and technically sound as well as consistent with the bilateral and regional development policies and strategies of A.I.D., other donors and the GOT. The project received a Categorical Exclusion determination on the Initial Environmental Examination which is in Annex K of the Project Paper. Adequate provisions are made in the Project Paper to satisfy all statutory requirements, including Gray Amendment Considerations. A Technical Notification was sent to the Congress on September 12, 1991 and expired on September 27, 1991 without objection. The Statutory Checklists are attached in Annex J of the Project Paper.

V. FINANCIAL SUMMARY:

It is planned that a multi-year project with an A.I.D. contribution totaling \$15.526 million in life of project funding will be approved. The first year obligation will be \$3,762,000. The host country cash and in-kind contribution will be \$5,543,889 and covers salaries, existing infrastructure, assumption of recurrent costs during the last three years of the project, and cost recovery. This contribution accounts for over 26% of project costs.

TOGO CHILD SURVIVAL AND POPULATION PROJECT
PROJECTION OF EXPENDITURES BY FISCAL YEAR TABLE
(US \$)

	AID PROJECT ASSISTANCE	GOT PROJECT CONTRIBUTION	TOTAL PROJECT
FY 1991	0	27,600	27,600
FY 1992	1,317,708	446,925	1,764,663
FY 1993	4,542,069	571,211	5,113,280
FY 1994	3,707,888	796,082	4,503,970
FY 1995	2,893,975	1,030,712	3,924,687
FY 1996	1,817,431	1,253,563	3,070,994
FY 1997	1,246,792	1,417,797	2,664,589
TOTAL	15,525,863	5,543,689	21,069,752

SUMMARY PROJECT FINANCIAL PLAN

<u>EXPENSE CATEGORY</u>	<u>AID</u>	<u>GOT</u>	<u>TOTAL</u>
<u>I. AID Contribution</u>			
Long-term Technical Assistance	3,040,000	0	3,040,000
Short-term Technical Assistance	481,000	0	481,000
Buy-ins, PASAs & contracts	2,930,000	0	2,930,000
Long-term Participant Training (US)	400,000	0	400,000
Short-term Participant Training	400,000	0	400,000
In-Country Training (Workshops)	1,065,000	0	1,065,000
Research and Studies	500,000	0	500,000
Commodities	3,634,750	0	3,634,750
Evaluations and Reviews	150,000	0	150,000
Audit	150,000	0	150,000
Revolving loan Fund (private Sector)	750 000	0	750,000
Contingency and Inflation	2,025,113	0	2,025,113
Total AID Project Asst.	15,525,863	0	15,525,863
<u>II. Host Country Contribution</u>			
Host-Country Salary Contribution	0	2,052,000	2,052,000
Host-Country Recurrent Cost	0	1,355,250	1,355,250
Host-Country Cost Recovery	0	1,413,523	1,413,523
Contingency and Inflation	0	723,116	723,116
Total Host-Country	0	5,543,889	5,543,889
TOTAL:	15,525,863	5,543,889	21,069,752

VI. IMPLEMENTATION RESPONSIBILITIES:

A. Grantee:

The MOHP will be the GOT entity responsible for project implementation. The Director General of the MOHP will be the authorized representative to the project, and the Director of the MOHP Directorate of Planning and Staff Training will be responsible for day-to-day management of the project.

B. A.I.D.:

A.I.D. will provide overall project management support and policy guidance to the project through the Office of the A.I.D. Representative, Lome. An OAR project management committee, chaired by the Health and Population Officer and staffed by one personal service contractor will be responsible for day-to-day management of the project on behalf of A.I.D.

C. Contractors:

The project will supply a variety of short and long term technical assistance, commodities and drugs, and various studies and surveys. A.I.D. will enter into contracts with U.S. and local institutions to assist in project implementation.

VII. CONDITIONS PRECEDENT AND SPECIAL COVENANTS

Conditions precedent for the project will require that qualified personnel have been identified and assigned to designated positions on the revised MOHP organizational chart; and that adequate internal controls and financial management systems will be in place prior to disbursing funds directly to the MOHP.

Special covenants of the project will require that appropriate project evaluations be undertaken; that project resources not be used to aid or facilitate price setting by the GOT; that revenue generated from cost recovery will be used appropriately; and that A.I.D. and the GOT agree that a private sector revolving loan fund will not be established under the project until adequate financial management procedures for use of the fund are certified by A.I.D. in writing, and approved by the MOHP.

VIII. PROJECT COMMITTEE ACTIONS AND FINDINGS:

On June 19, 1991, the Assistant Administrator of the Africa Bureau approved the Project Identification Document (PID), and delegated the authority under DOA 551 to the A.I.D. Representative to Togo to approve and authorize the project, subject to the concurrence of the REDSO/WCA Director.

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PROJECT AUTHORIZATION

Country: REPUBLIC OF TOGO

Project Name: TOGO CHILD SURVIVAL AND POPULATION PROJECT

Project Number: 693-0234

1. Pursuant to Section 496 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Togo Child Survival and Population Project (TCSP) ("the Project") for the Republic of Togo. The Project will involve planned obligations of not to exceed Fifteen Million Five Hundred and Twenty six Thousand United States Dollars (US \$15,526,000) in grant funds ("the Grant") over a six year period from the date of initial obligation, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing foreign exchange and local currency costs for the Project. Except as A.I.D. may otherwise agree in writing, the planned life of project is six years from the date of initial obligation.

2. The purpose of the Project is to improve delivery of family planning and maternal and child health services so as to increase contraceptive prevalence and maternal and child survival. To achieve this purpose the Project will consist of the following components: 1) Improving Ministry of Health and Population (MOHP) management, and expanding the public sector health and family planning cost recovery program; 2) Strengthening integrated and decentralized health and family planning service delivery; 3) Promoting public and private sector collaboration in health and family planning; and 4) Expanding and strengthening private sector health and family planning service delivery.

3. The Project Agreement which may be negotiated and executed by the officer(s) to whom such authority is delegated in accordance with A.I.D. regulations and delegations of authority shall be subject to the following essential terms, covenants, and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate and agree to in writing:

A. First Disbursement. Prior to the first disbursement under the Grant, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the Grantee shall, except as the Parties may otherwise agree in writing, furnish to A.I.D., in form and substance satisfactory to A.I.D.:

(i) A statement of the names of the persons holding or acting in the office of the Grantee specified in Section 8.2., and a specimen signature of each person specified in such statement.

(ii) A statement of legal counsel confirming that the Agreement, as signed by the Grantee, represents a binding commitment on the part of the Republic of Togo to all of its terms and conditions.

B. Long-term Technical Assistance. Prior to any disbursement under the Grant for long-term technical assistance, or to the issuance of any documentation by A.I.D. pursuant to which disbursement will be made for long-term technical assistance, the Grantee shall demonstrate, in form and substance satisfactory to A.I.D., that qualified personnel have been identified and assigned to the following positions on the revised MOHP organization chart, or that other arrangements, satisfactory to A.I.D., have been made to assure functional counterparts for long-term technical advisors:

- 1) Director of the Directorate of Planning and Staff Training;
- 2) Director of the Division of Planning;
- 3) Director of the Division of Staff Training;
- 4) Director of the Division of Statistics;
- 5) Director of the Directorate of Finance and Administration;
- 6) Director of the Division of Finance;
- 7) Chief of the Infrastructure and Maintenance Service;
- 8) Director of the Directorate of Primary Health Care;
- 9) Director of the Directorate of Health Facilities;
- 10) Director of the Division of Private Health Facilities;
- 11) Director of the Directorate of Pharmacies, Laboratories, and Technical Equipment.

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C. Additional Disbursement. Prior to the disbursement of any funds under this Grant directly to the MOHP, or to the issuance by A.I.D. of documentation pursuant to which such disbursement may be made, the Grantee will provide evidence, in form and substance satisfactory to A.I.D., that the MOHP has put into place sufficient internal controls and financial management systems to assure that the procurement and accounting functions of the MOPH may reliably undertake contracting and procurement responsibilities under the Agreement.

D. Special Covenants

(i). Project Evaluation. The Parties covenant to establish an evaluation program as part of the Project. Except as the Parties otherwise agree in writing, the program will include, during the implementation of the Project and at one or more points thereafter: (a) an evaluation of the progress towards the attainment of the objectives of the Project; (b) identification and evaluation of problem areas or constraints that may inhibit such attainment; (c) assessment of how such information may be used to help overcome such problems; and (d) evaluation, to the degree feasible, of the overall development impact of the Project on the rural economy.

(ii). The Parties covenant that resources contributed or generated under this Agreement shall not be used to aid or facilitate public sector participation in the establishment of prices, or other activities which may likely have the effect of constraining competition in the health sector.

(iii). The Parties covenant that revenue generated from cost recovery activities under the Agreement shall be used to purchase replenishment stocks of sold products and inputs for the provision of services; revenues received in excess of costs incurred shall be retained at each health facility according to guidelines to be established by the MOHP for reprogramming to improve health services.

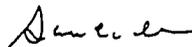
(iv). The Parties covenant that a private sector revolving loan fund will not be created under the Project until adequate financial management procedures for use of the fund are certified by A.I.D. in writing, and approved by the MOHP.

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E. Source and origin of commodities, nationality of suppliers:

(1) Commodities financed by A.I.D. under the Project shall have their source and origin in countries included in A.I.D. Geographic Code 935, except as A.I.D. may otherwise agree in writing.

(2) The suppliers of commodities or services, including ocean shipping, financed by A.I.D. under the Project shall have countries included in A.I.D. Geographic Code 935 as their place of nationality, except as A.I.D. may otherwise agree in writing.



Sarah C. Clark
A.I.D. Representative to Togo

30 SEP. 1991

Date

TOGO CHILD SURVIVAL AND POPULATION PROJECT

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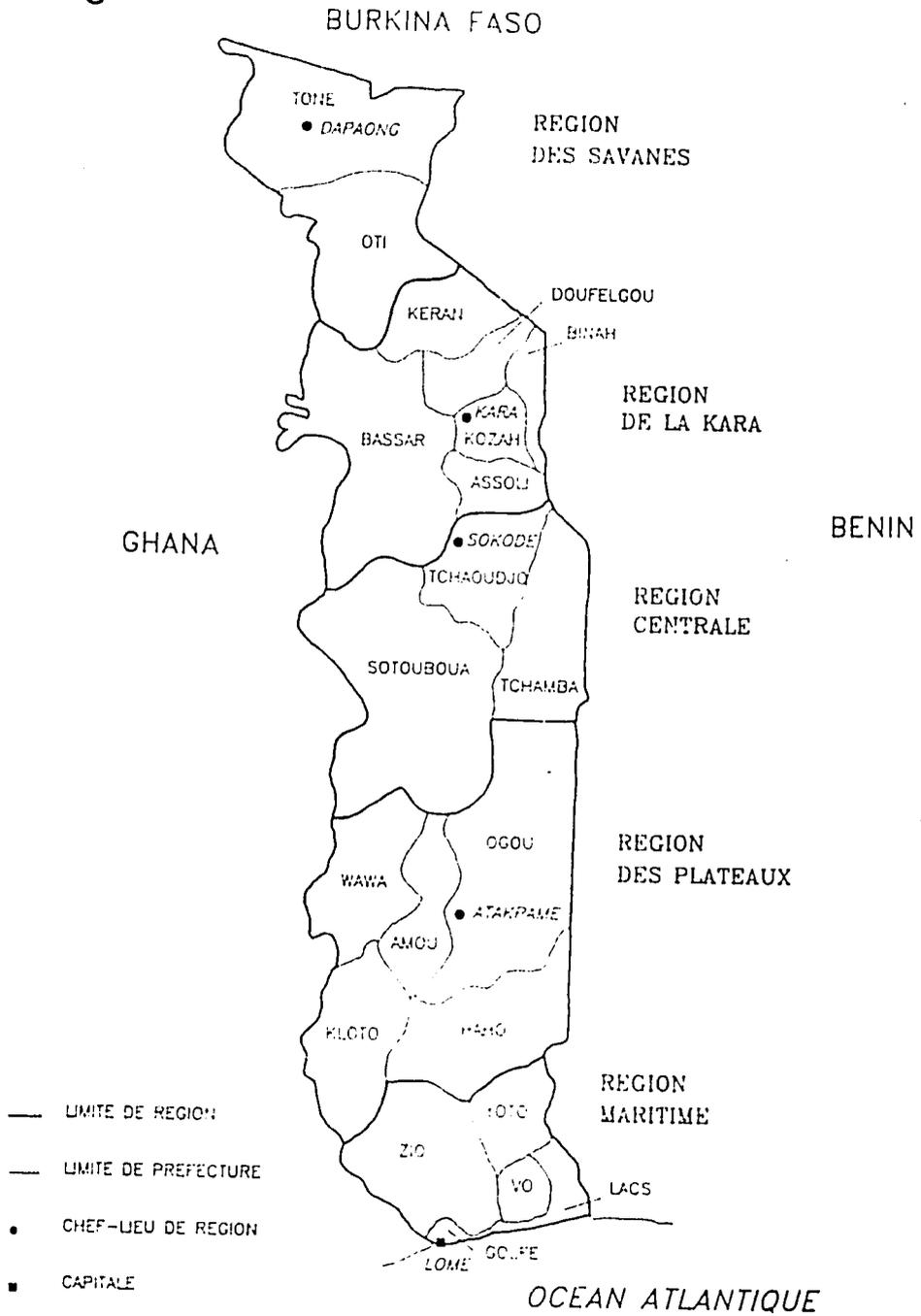
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ACRONYMS AND ABBREVIATIONS

ATBEF	Association Togolaise pour le Bien-Etre Familiale - Togolese Family Planning Association
AVT	Action Vaccination Togo -- Immunization Action Program of Togo
CBD	Community Based Distribution
CCCD	Combatting Childhood Communicable Diseases Project (USAID-funded)
CDD	Controlling Diarrheal Diseases
CHR	Centre Hospitalier Regionale (Regional hospitals)
CHU	Centre Hospitalier Universitaire (University Teaching Hospital)
CPC	Controle et Promotion de la Croissance -- Growth Monitoring
CNI	Centre de Nutrition Infantile -- Child Nutrition Center (Social Affairs/Cathwell)
CNSS	Caisse National de Securite Sociale -- National Social Security Agency
CUSO	Canadian University Service Overseas
CVD	Comite Villegois de Developpement -- Village Development Committee
DHS	Demographic Health Survey
DME	Division de la Mere et de l'Enfant -- Division of Mother and Child Health
DRDR	Direction Regionale du Developement Rural -- Rural Development Ministry (Regional Office)
EPI	Expanded Program of Immunization (national vaccination program)
FAC	Fonds d'Aide et de Cooperation -- French Foreign Assistance Agency
FED	Fonds Europeen de Developpement -- EEC Foreign Assistance Agency
FHI-II	Family Health Initiatives II Project (USAID-funded)
FP	Family Planning
GOT	Government of Togo Organization
GTZ	German Development Assistance Organization
HIS	Health Information System - eidemiological data
H/MIS	Health Management Information System
HSSCS	Health Sector Support for Child Survival Project (USAID-funded)
IEC	Information, Education and Communication
INTRAH	Program for International Training in Health (AID central FP training project)
IPPF	International Planned Parenthood Federation
KAP	Knowledge, Attitudes and Practices Study
LMD	Lutte Contre les Maladies Diarrheique ---- Controlling Diarrheal Diseases
MASCF	Ministere des Affaires Sociales de de la Condition Feminine
MOSAWC	Ministry of Social Affairs and Women's Condition
MCH	Maternal and Child Health

MOPH	Ministry of Public Health
MSP	Ministere de la Sante Public -- Ministry of Public Health
NGO	Non-governmental Organization
OCCGE	Organisation de Coordination et de Cooperation pour la Lutte Contre les Grandes Endemies -- Organization of Coordination and Cooperation for Control of Endemic Diseases
OMS	Organisation Mondiale de la Sante -- World Health
ORS	Oral Rehydration Salts (packets)
ORT	Oral Rehydration Therapy Organization
PEV	Programme Elargi de Vaccination -- Expanded Program of Immunization
PHC	Primary Health Care
PMI	Programme Maternal et Infantile -- Maternal and Child Health Program
PNBEF	Programme National pour le Bien-Etre Familial -- National Family Planning Program (Government of Togo)
REDSO/WCA	Regional Economic Development Services Office/West and Central Africa (USAID)
RPT	Rassemblement du People Togolais -- Togolese People's Party
SEATS	Service Expansion and Technical Services Project (AID-funded central FP activity)
SMI	Sante Maternelle et Infantile (Mother and Child Health)
SNES	Service National de l'Education pour la Sante -- National Health Education Service
SOMARC	Social Marketing for Change (centrally-funded AID project promoting sales of contraceptives)
SSS	Sugar and Salt Solution (Home based recipe for ORT)
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
UPC	Unite de Planification et de Coordination -- Planning and Coordination Unit of Ministry of Public Health
WHO	World Health Organization

Togo



EXECUTIVE SUMMARY

TOGO CHILD SURVIVAL AND POPULATION PROJECT

A. Summary:

The Togo Child Survival and Population Project (TCSP) is a \$15.526 million, six year project, which aims to improve the efficiency and sustainability of the Government of Togo (GOT) Ministry of Health and Population's (MOHP) service delivery capacity, especially for women and children. It will also increase cooperation and information sharing between the MOHP and the private sector, and strengthen and improve private health practitioners' ability to deliver health and family planning services in under-served areas. Initial obligation of funds for the project will be made in September 1991. Project implementation will extend to FY 1997.

B. Project Background :

Over the past 15 years, Togo has approximately doubled the ratio of doctors and nurses in relation to the number of people served. Over the same period, the infant mortality rate has been cut almost in half. These and other improvements to the overall health status of the Togolese people have resulted in the life expectancy at birth increasing to approximately 53 years.

The MOHP has expanded and improved services in facilities throughout the country, particularly over the last 20 years. With assistance from the World Health Organization (WHO), the United Nations Children's Fund (UNICEF) and A.I.D., it has recently significantly improved immunization coverage and reoriented the malaria program's treatment policy in response to changing conditions.

The recording and reporting of epidemiological data by the Ministry has improved with the assistance of A.I.D.'s Combatting Childhood Communicable Diseases (CCCD) program. The MOHP recently has improved the quantity and quality of its statistical data; expanded information available for management; and increased its capacity to interpret and analyze collected data.

C. Statement of the Problem:

Despite progress made, maternal and child morbidity and mortality, and high population growth remain significant public health problems in Togo. Infant mortality is estimated at 80 per thousand live births, and child mortality (0-4 yrs) at 158/1000 live births. Malaria and other infectious diseases, including diarrhea, are the major causes of death. Low nutrition and anemia contribute to both maternal and child morbidity and mortality.

Population growth is estimated by the Government to be 2.9% with a birth rate of 45 per thousand live births. According to the

of at least one contraceptive method. Only an estimated sixteen percent of the MOHP service delivery sites presently are providing the full range of modern family planning services.

Progress in the provision of health and family planning services was constrained by severe economic downturns in the early part of the 1980s, leading to restricted GOT funding for the health sector. In addition, three sector specific factors have impeded additional progress:

- (1) Insufficient coordination and integration of donor assistance into MOHP programs and administrative systems;
- (2) Insufficient MOHP capacity to plan, manage, and coordinate decentralized health service delivery; and
- (3) Insufficient development of private sector health services.

D. Project Objectives:

The goal of the project is to increase life expectancy and reduce the population growth rate, leading to an improvement in the health status of the population of Togo.

The purpose of the project is to improve delivery of family planning and maternal and child health services so as to increase contraceptive prevalence and maternal and child survival.

The project has four strategic objectives. These are to:

- 1) Improve coordination, planning, budgeting, personnel management, and logistical support at MOHP central and prefectural levels;
- 2) Reinforce community participation in service delivery and establish a functioning local cost recovery system in the public sector;
- 3) Integrate, improve, and expand MOHP service delivery programs at all levels; and
- 4) Expand private sector health and family planning service delivery to under-served areas.

E. Project Components:

The project consists of four components which are: (1) improving MOHP management and expanding the public sector health and family planning cost recovery program; (2) strengthening integrated and decentralized health and family planning service delivery; (3) promoting public and private sector collaboration in health and family planning; and (4) expanding and strengthening private sector health and family planning service delivery. These four components are outlined below:

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Component One. Improving MOHP Management and Expanding the Public Sector Health and Family Planning Cost Recovery Program:

MOHP Management Improvement

The improved management of the MOHP will comprise the following:

- (a) establishing a functioning Directorate of Planning and Staff Training;
- (b) improving the Directorate of Finance and Administration's capabilities to provide personnel management, financial services, and logistical support;
- (c) assisting the Prefectoral Chief Medical Officers to better supervise and manage their resources;
- (d) simplifying and integrating the existing health statistics and management information systems; and
- (e) improving MOHP capabilities to distribute essential drugs and medical supplies to all levels.

To achieve the project purpose the MOHP must develop a clear, shared definition of policy for the sector, standards and guidelines for management and service delivery, and a comprehensive integrated management information system (MIS). The development of the MIS, and well articulated policies and professional standards and guidelines will strengthen decentralized decision-making and supervision, and promote coordination within the MOHP. These efforts, in turn, will enhance the delivery of child survival, maternal health, and family planning services.

This Project component will support changes in the Statistical Division of the MOHP, enabling it to serve as the central source for data collected by the Ministry. Through the publication of quarterly reports and an annual yearbook, and by responding to specific requests from other MOHP units, this Division will provide the statistical information needed by the MOHP for improved management of health delivery.

This Division will also serve as a resource for the MOHP in resolving computer-related problems within the Ministry. The processing of data collected through special studies and operational research also will be the responsibility of this Division. Finally, the Division will work with other Ministries to coordinate data collection efforts and exchange relevant information on the sector.

This project component also will reinforce the Training Division's capacity to coordinate in-service training programs, as well as track MOHP personnel previously trained. The Training Division will work with the National Health Education Service (SNES) to refine existing curricula, and develop training materials on generating and using a monthly reporting system that will feed into the MIS.

Finally, this component will assist in the establishment of a documentation center for the Ministry at the central level. This documentation center will collect, classify, and maintain all major documents produced in the health sector, as well as related documents from other Ministries and outside sources.

Public Sector Cost Recovery

The project's objectives in promoting the expansion of a public sector health and family planning cost recovery program are to establish community participation in service delivery and to promote a functioning cost recovery system at all levels. Final project accomplishments are expected to be as follows:

(a) Village Development Committees (CVD) and health sub-committees will be developed and trained under the project in areas surrounding the 400 existing MOHP health facilities. These committees will work to define community needs, to promote health education for child survival, maternal health and family planning, and to supervise the management of funds collected from fees for health care services and essential medicines.

(b) A system for the collection of fees for medical consultations, contraceptives, and essential medicines and supplies will be put in place to help cover the basic non-salary recurrent costs of health care facilities.

(c) The present pharmaceutical distribution system within the MOHP (PharmaPro) will be strengthened to meet the increased demand for generic essential drugs. PharmaPro will be strengthened organizationally and logistically to provide the needed drugs, contraceptives and other required supplies on a timely basis to assure that these commodities are always available in peripheral health facilities.

Basic inputs to cost recovery activities under the Project will consist of a significant portion of the time of the Financial Management/Logistics Specialist after his/her first 6 months of residence. This Advisor will assist in developing a national cost recovery system by the end of 1994. This will require the training of CVD members and management committees in villages where the 400 MOHP facilities presently exist over a span of approximately 24 months (January 1993 to December 1994). Developing these courses in conjunction with other donors will be largely the responsibility of the Training Division with assistance from the Health Training Advisor.

Illustrative Inputs for this component include:

LONG TERM TECHNICAL ASSISTANCE:

Health Planner and management expert (60pm);
 Management Info System Coordinator/Programmer(36pm);
 Facilities Management/Logistics Specialist (36pm);
 Health Sector Continuing Education Expert (24pm);

Financial Management Advisor (36pm);
 Project Administrative Assistant (60pm).
 Private Sector Health Specialist (36 pm)

SHORT TERM TECHNICAL ASSISTANCE:

Private Sector Oversight (6 pm);
 Operations Research (6 pm);
 Health Trainers (12 pm);
 Documentalist (6 pm);
 Health Education Planner (2 pm);
 Nutrition Planner (5 pm).

LONG TERM PARTICIPANT TRAINING:

MPH Health Management; MS Information Systems Management; MS Health Statistics; MPH Health Administration & Logistics; MS Health Training Management; MPH/MS Epidemiology; MS/MA/MPH in Health Finance and Economics.

SHORT-TERM PARTICIPANT TRAINING: (outside Togo)

Medical Equipment Repair; PHC Information System Management; Managing Drug Supply for PHC; Financial Management for Health; IEC materials development; Child Survival/MCH technical; Integrated PHC/Management; Nutrition and PHC; Family Planning technical; Cost Recovery Field Visits; Motor Pool Management; Drug Supply Logistics.

IN-COUNTRY TRAINING:

Financial Management; Planning and Budgeting; Monthly Report Record Keeping and Management; Computer Applications; Technical training for program interventions (3 integrated modules); Supervision; Village Development Committee management; Stock Control and Financial Record Keeping; Motor Pool Driver Training; Laboratory techniques.

RESEARCH AND STUDIES:

Operational Research Studies in Medical, Technical and Management areas.

EQUIPMENT AND MATERIALS:

Vehicles; Fuel for vehicles and supervision; Photocopiers; Printing materials; Doc. Center Equip.; Tool kits Medical Equipment repair; Computers (21 Prefectures, 9 Central level + computers from existing AID projects).

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COMPONENT TWO. Strengthening Integrated and Decentralized Health and Family Planning Service Delivery:

The objective of this component is to promote integration and coordination among the different MOHP programs. The development of the integrated management information system described above in Component One will be the foundation of overall program integration. Component Two will encourage decentralization and delegation of responsibility to the prefectural level by making more inputs available directly to prefectural medical teams.

This component will promote integration of training, management, supervision, logistics, and service delivery. This will be accomplished by the creation of multi-purpose Prefectural Public Health teams headed by the Chief Medical Officers. These teams will:

a) Provide medical and technical expertise for all MOHP program interventions; b) train health staff in all interventions; c) supervise all interventions; and, d) manage and provide logistic support for all interventions.

The project will assist the MOHP in the development of a decentralized model of health services delivery through the following illustrative steps.

Needs Assessment: The Division of Planning will be responsible for conducting in-country surveys that will include, inter alia, a facilities and equipment survey; knowledge, attitude and practices (KAP) surveys; and staff skills assessments. The latter will serve as the basis for developing both a national training curriculum and training materials to be used at the prefectural level.

Technical Training in Child Survival and Family Planning: This capacity will be developed through the establishment of three integrated cycles of related technical training concerning specific MOHP service delivery programs. Depending on the stage of development of a given technical program, diagnostic and treatment protocols, as well as drug use manuals will be developed if not already available. Cascade training modules will be developed for health personnel at the prefectural level according to the illustrative outlines below:

Cycle One will cover the Expanded Program of Immunization (EPI), Malaria control, and the control of Acute Respiratory Infections (ARI);

Cycle Two will cover Nutrition, Growth monitoring, Nutrition Rehabilitation, and Control of Diarrheal Diseases (CDD); and

Cycle Three will cover Safe Motherhood, Family Planning, and AIDS control.

Added to these technical training modules will be the training module in the use of the integrated management information system, and the new monthly reporting forms, described above under Component One.

Supervision: The MOHP plans to develop technical reference guides (standard treatment protocols, drug use guides, diagnostic guides, etc.) and administrative operations manuals for logistics, accounting, and information systems. The project will assist where necessary to complete these materials. These guides will be provided to all health facilities through training sessions, and will subsequently be used as reference materials by local health personnel. Using these materials as a foundation, simplified supervisory checklists will be developed for use by the prefectoral teams. The project will provide logistics support (gas coupons) to encourage the prefectoral teams to carry out their supervisory, management, and training-related visits to prefectoral health facilities.

Inputs to this component, in addition to long term technical assistance outlined under Component One above, are the following:

SHORT TERM TECHNICAL ASSISTANCE

Medical and Technical Advisors (36 months) from CDC/Atlanta for assistance in EPI, CDD, Malaria, and other medical issues as appropriate;

US\$2.6 million will be made available to procure technical assistance from the following A.I.D. Regional Projects in the areas of Family Planning, IEC, Health Financing, MCH services, etc.: SEATS, INTRAH, Mothercare, SOMARC, OPTIONS, Health Financing & Sustainability, PCS/Johns Hopkins, IRD(DHS), MSH/Managing Drug Supply Program, and others as appropriate.

MATERIALS

Materials and equipment will be provided to improve prefectoral laboratory capacity. They will include, inter alia, refrigerators for EPI, and equipment and supplies in support of improved maternal and child health and family planning services. The needs in this area will be defined during the first year as facilities and equipment inventories are established for all facilities. Included in this component will be financing for the purchase of drugs, vaccines and contraceptives in support of ongoing programs, as well as gas coupons to support mobility of the prefectoral medical teams and encourage increased supervision.

COMPONENT THREE. Promoting Public and Private Sector Collaboration in Health and Family Planning.

This component comprises the development of the MOHP's capacity to monitor, collaborate, establish standards, and provide technical extension services to private practitioners, community health cooperatives, laboratories, and pharmaceutical vendors. The focus of such assistance will be to integrate private providers into national health education, statistics, and training networks; to ensure professional standards for quality of care and health professional certification; and to rationalize household expenditures for essential health care, while allowing market mechanisms to operate efficiently.

Project assistance to this component will be essentially technical, and will include:

LONG TERM TECHNICAL ASSISTANCE

A Private Sector Health Care Advisor (36 months) to be advisor to the Director of the Directorate of Health Care Facilities. The incumbent will assist the Ministry in monitoring private sector service delivery and distribution networks. The incumbent will also coordinate (a) the incorporation of private sector statistics into national health statistics, and (b) the inclusion of private sector professionals in health education and training programs to ensure the attainment of primary health care objectives.

SHORT TERM TECHNICAL ASSISTANCE

A Health Sector Regulatory Advisor (6 months) will provide guidance and training on licensing requirements for private sector health professionals at all levels; codification of medical procedures permitted for each level of health professional; and guidance on legal, financial, and administrative issues related to the establishment of additional private health facilities and the importation and sale of drugs and medical equipment.

COMPONENT FOUR. Expanding and Strengthening Private Sector Health and Family Planning Service Delivery:

Under this component, the services of the Private Sector health advisor will be utilized to identify opportunities for the expansion of private sector health care. The focus will be primarily on private sector organizations or associations with the potential capacity to manage a revolving loan fund to be financed by the project. The loans will be provided to health professionals so they can start new private practices, particularly in presently medically under-served areas. Technical assistance will be provided in loan fund management and in private sector clinic administration management to participants in the revolving loan fund program.

The associations receiving financial assistance from the project will establish, with assistance of the MOHP and USAID, criteria for the issuance of loans to the private sector which best serve the primary health care needs of Togo.

F. End of Project Status

The project will establish the following targets as indicators for achievement of the project purpose.

(a) Health management information system for MOHP developed and implemented in all 30 prefectures by 1994. System will include health statistics, program-related, personnel, logistics, and financial information;

(b) Integrated system to collect information on technical program-related interventions developed and implemented by the central statistics office by 1994;

(c) Information on the private sector will be included in GOT annual health statistics by 1995;

(d) Standard treatment and drug utilization protocols developed and implemented for priority child survival interventions by 1994;

(e) Integrated supervisory protocols based on the above standard treatment and drug protocols developed and implemented for prefectural level supervision by 1994;

(f) Public sector cost recovery system developed and established in all 397 health facilities by 1997 based on sales of essential drugs, contraceptives, and consultation fees, where appropriate;

(g) Functioning Village Development Committees will be established by 1994 in the 397 communities where public health facilities are located. These committees will control local facilities for quality of care, and manage the local currency fund generated by the cost recovery system;

(h) 30 multi-purpose prefectural public health teams trained and providing technical, administrative, training, and supervisory support in each prefecture by 1996;

(i) The full range of modern family planning services will be offered in 60% of MOHP public health facilities by 1997; 80% will offer all methods except the IUD, and 100% will offer non-medical family planning methods;

(j) 30 prefectural teams trained and submitting annual work plans and budgets by September of each year for the following year's Government budget submission. All teams will be trained by 1995;

(k) MOHP guidelines for professional standards, and criteria for different categories of health personnel to open private health care facilities approved by GOT by 1995;

(l) Essential drug list by category of health facility approved by MOHP, and essential drugs being distributed at least quarterly to all health facilities by 1997;

(m) Twenty-five new private sector health facilities will be established outside of Lome by 1997. These facilities may be managed by physicians or other para-professional personnel according to standards to be established by the MOHP;

(n) Contraceptive prevalence rate increased from 3% to 12% for modern methods;

G. Outputs

The following outputs will be achieved by the project by 1997:

75% reduction achieved in reported cases of neonatal tetanus;

35% reduction in reported cases of diarrheal diseases;

90% of pregnant women receive prenatal care;

80% of birth deliveries are attended by qualified personnel;

90% of women who give birth in MOHP facilities receive tetanus toxoid #2;

80% of children aged 12-23 months immunized by antigen;

50% of children under 5 are growth monitored;

50% of children under 5 with diarrhea receive ORT;

Condom use increased to 10% in populations with multiple sex partners;

Quarterly reports on AIDS cases and seropositivity in established sentinel groups published by MOHP;

Yearly sales of condoms through the social marketing program reaches 3,000,000.

H. Financial Summary

It is planned that a multi-year project with an A.I.D. contribution totaling \$15,526,000 in life of project funding will be approved. The first year obligation will be \$3,762,000. The host country cash and in-kind contribution will be \$5,543,889,

and covers salaries, existing infrastructure, assumption of recurrent costs during the last three years of the project, and cost recovery. This contribution accounts for over 26% of project costs.

SUMMARY PROJECT FINANCIAL PLAN (\$US)

<u>EXPENSE CATEGORY</u>	<u>AID</u>	<u>GOT</u>	<u>TOTAL</u>
I. <u>AID Contribution</u>			
Long-term Technical Assistance	3,040,000	0	3,040,000
Short-term Technical Assistance	481,000	0	481,000
Buy-ins, PASAs & contracts	2,930,000	0	2,930,000
Long-term Participant Training (US)	400,000	0	400,000
Short-term Participant Training	400,000	0	400,000
In-Country Training (Workshops)	1,065,000	0	1,065,000
Research and Studies	500,000	0	500,000
Commodities	3,634,750	0	3,634,750
Evaluations and Reviews	150,000	0	150,000
Audit	150,000	0	150,000
Revolving loan Fund (Private Sector)	750 000	0	750,000
Contingency and Inflation	2,025,113	0	2,025,113
Total AID Project Assistance	15,525,863	0	15,525,863
II. <u>Host Country Contribution</u>			
Host-Country Salary Contribution	0	2,052,000	2,052,000
Host-Country Recurrent Cost	0	1,355,250	1,355,250
Host-Country Cost Recovery	0	1,413,523	1,413,523
Contingency and Inflation	0	723,116	723,116
Total Host-Country	0	5,543,889	5,543,889
TOTAL:	15,525,863	5,543,889	21,069,752

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I. Non-project Assistance

Upon the advice and recommendation of the A.I.D./W Executive Committee Project Review (ECPR) for this project, OAR/Lomé and the MOHP plan to develop a subsequent health sector non-project assistance (NPA) component to the present project. The design of the NPA program, including the necessary analyses will take place during Year One of this project's implementation. A Program Assistance Approval Document (PAAD) will be developed by OAR and the MOHP, for subsequent approval, and inclusion as part of this project.

J. Evaluation Plan

The project will have an external evaluation at the end of years three and six, and internal reviews at the end each of the other years. Independent audits will be conducted every two years.

The internal reviews will involve personnel from the MOHP, OAR and the technical assistance team in joint assessment of project progress. The external evaluations will involve personnel from the Ministries of Finance and Plan along with external consultants for an independent assessment of project progress. The external audits will be conducted by a qualified independent accounting firm.

K. Conditions Precedent and Special Covenants

Conditions precedent for the project will require that qualified personnel have been identified and assigned to designated positions on the revised MOHP organizational chart; and that adequate internal controls and financial management systems be in place prior to disbursing funds directly to the MOHP.

Special covenants of the project will require that appropriate project evaluations be undertaken; that project resources not be used to aid or facilitate price setting by the GOT; that revenue generated from cost recovery be used appropriately; and that A.I.D. and the GOT agree that a private sector revolving loan fund will not be established under the project until adequate financial management procedures for use of the fund are certified by A.I.D. in writing, and approved by the MOHP.

L. Beneficiaries

The project will create a framework through which efficient and cost effective health and family planning services can be delivered by the MOHP and the private sector. The initial beneficiaries are the staff of the MOHP -- who will receive both on the job and long and short-term training, and the private sector health service providers who will benefit from the obtention of project loans to begin their private practices outside Lomé. The ultimate beneficiaries are the 750,000 women of reproductive age and 600,000 (0-4 years) children, who will receive integrated and comprehensive health and family planning services.

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M. Implementation and Contractor Selection

Initial funds for the project will be obligated by A.I.D. at the end of FY 1991. Project Implementation will effectively take place between FY 92 and FY 97. During the first year of implementation, terms of reference for the selection of a technical assistance contractor will be developed by the OAR and the MOHP. The selection of the contractor will take place in FY 92, with actual technical assistance personnel as described herein arriving toward the end of FY 92.

N. Conclusion and A.I.D. Recommendation

The project is in conformity with A.I.D. and OAR/Togo policies and strategies for the delivery of child survival and maternal health and family planning services. The project addresses systemic and structural problems identified by both the GOT and A.I.D. as constraints to the delivery of effective health and family planning services. The feasibility analyses, including the economic, financial, institutional, technical, and social analyses, indicate that the project is an appropriate mechanism for improving health and family planning service delivery to the Togolese population. Therefore, it is recommended that the Togo Child Survival and Population Project be authorized in FY 1991.

The Project Agreement will contain a special provision under which the Parties will agree that a private sector revolving loan fund will not be established under the project until adequate financial management procedures for use of the fund are certified by A.I.D. in writing, and approved by the Togolese Ministry of Health and Population.

II. PROJECT BACKGROUND AND RATIONALE

A. Economic and Political Context

Togo is a small country (57,000 kms) with a population of 3.5 million. Roughly 80% of its population is engaged in agriculture, which is based on the production of food crops and cash crops (cotton, coffee, and cocoa). The country also produces phosphate rock for export. Togo is relatively well-endowed with a highway network and secondary roads; equipped with a well-managed banking system, the country plays an important regional role as a trading and financial center. Nevertheless, Togo is fundamentally a poor country with a GDP per capita of about \$390.

By the late 1970's Togo began to experience increasing macro-economic difficulties, a consequence of sharp falls in phosphate, coffee, and cocoa prices. The country entered the 1980s with greatly increased external indebtedness, internal and external macro-economic disequilibria, and an economy burdened by inefficient state enterprises and numerous structural rigidities.

In response to this deteriorating situation, the GOT began a series of structural adjustment programs supported by the IMF and the World Bank. The country is presently engaged in its Fourth Structural Adjustment Program (1990-1992). Under the present structural adjustment effort which provides the policy and macro-economic environment for the World Bank's Population and Health Sector Adjustment Program, the Government seeks to increase real GDP growth to 4% by 1992; to limit the rate of inflation to 3% or less; to reduce the external current account deficit; and to improve the provision of social services, with particular emphasis on access to services by the most vulnerable groups.

Since the inception of the First Structural Adjustment Program in 1983, the GOT has made progress in redressing the situation of the late 1970s and early 1980s. Fiscal and current account deficits as a proportion of GDP have been reduced relative to the pre-adjustment levels. Structurally, government operations have been streamlined, particularly in the previously bloated state enterprise sector. Price distortions have been reduced and private sector incentives created in recent years.

In spite of a relatively strong productive response in the late 1980s, self-sustaining growth and development have not yet been achieved. Moreover, with continued fiscal constraints, spending levels and allocations in the health and education sectors need careful management to ensure appropriate human resource development over the long term. Under the World Bank's Social Dimensions of Adjustment Project, monitoring of social conditions has begun in Togo.

The World Bank's Population and Health Sector Adjustment credit, as described in Section F below, is a direct response to the concern over the potential for serious deterioration of living

and health standards as the Togolese economy continues to remain heavily dependent on low prices and unfavorable prospects in the world markets for its traditional cash crops.

The Population and Health Sector Adjustment Program was designed by the World Bank to support the social aims of the Government's Fourth Adjustment Program which emphasizes the development of human resources and the improvement of social conditions, particularly in rural areas. The Population and Health Sector Adjustment Program was designed with the MOHP to serve as an overall sector framework for both Government and donor activities. The International Development Assistance (IDA) Sector Adjustment credit planned for \$14.2 million over a period of four years (1991-1994) is slightly less than the proposed USAID Togo Child Survival and Population (TCSP) project.

With deteriorating economic conditions and reduced government spending for investment in recent years, social and political unrest has increased in Togo. During the first half of 1991 serious civil unrest occurred, leading to the acceptance by the President and his government of a Sovereign National Conference to debate the issues of greater democracy and openness in the Togolese polity and society. Following the Conference, a new government will be named by a new prime minister, who will be chosen by the Conference.

Recent political developments in Togo lead one to believe that profound changes at the highest level of the political system are likely to happen soon. The present climate, while still uncertain with regard to the details of the changes that will occur, holds promise for increased possibilities to implement more flexible and responsive systems in the future.

Modified administrative systems will in turn lead to changes in the way the GOT in general, and the MOHP in particular, do business. It should allow for a much-needed relaxation of central government control and support for more decentralization throughout the system.

If these changes are to have any chance of succeeding, the MOHP must strengthen its own internal management and administrative systems to take best advantage of the possible openings, and be ready to utilize lower level personnel in making planning and implementation decisions.

Pressures for government liberalization and a relaxation of the government's control over the economy in Togo have reached a point of no return. In spite of this, it appears that the transition will be peaceful, and the donor agencies' ability to work with current technical counterparts in key ministries, such as the Ministry of Health and Population, should not be affected by changes in political personnel at the higher levels.

B. Health and Population Profile

Togo's population is estimated at 3.5 million (IBRD 1990), and is growing at 2.9 Percent per year (Ministry of Plan). About 75 percent of the population is rural. The life expectancy of 53, coupled with the high population growth rate has produced a young population distribution, with nearly 50 percent below the age of fifteen. The 1988 Demographic and Health Survey (DHS) reported an infant mortality rate of 80 per thousand, and a child mortality rate of 158 per thousand for the period 1983-1988. In 1989, mortality in the under 5 age group accounted for almost 40% of the total reported deaths (Statistiques Sanitaires, 1989).

National Health Statistics for 1989 revealed the following pattern of causes for total consultations in the public health system: malaria (34%), wounds/trauma (10%), respiratory infections (9%), diarrhea (8%), conjunctivitis (5%) and worms/parasites (4%). Infectious and parasitic diseases alone accounted for a total of 55% of total morbidity in 1989.

The leading causes of death in hospital in 1989 as reported by the MOHP were: malaria (14%), anemia (8%), respiratory infections (6%), malnutrition (6%) and diarrhea (5%).

Undernutrition, malnutrition, and protein/energy deficiencies are important factors contributing to poor health status in Togo. In 1988, 50% of all consultations among children 1-4 years old were nutrition deficiency related. The DHS survey reported that 32% of children under 5 weigh less than 80% of the weight-for-age standard recommended by the WHO. The DHS survey also reported that among children under five 30.6% were suffering from chronic and 5.3% from acute malnutrition.

Hospital records in Lomé show that 10% of all childhood admissions relate to cases of severe malnutrition. Anemia represented the second cause of death among children under five in 1989 (Statistiques Sanitaires). In 1985, it was further reported that 48% of women were anemic at the time of giving birth (OCCGE Nutrition Study).

Togo's reported maternal mortality rate of 476 per 100,000 is high compared to other African countries' recorded rate of mortality (about 300 per 100,000 for Botswana and Cameroon, IBRD 1990). The accuracy of the data on the rate of maternal mortality in Togo must be taken with some caution since detailed studies in the area have not been undertaken, and existing small studies in Lomé and elsewhere range from 400-800 per 100,000. Only approximately 50% of the total births in Togo take place under medical supervision (DHS 1988). Within this figure there are important rural-urban differences (only 42% received medical assistance in rural areas, as compared to nearly 90% in urban areas).

Closely related to the health status of the approximately 600,000 children under the age of five is the high fertility rate which averages nearly seven children per woman (IBRD 1990). Although

33.9% of all married women interviewed in the DHS reported using at least one contraceptive method, only 3% were using more reliable modern methods. Knowledge of family planning methods was reported at nearly 40% for spontaneous recollection among women interviewed, and 90% after prompting (DHS 1988). The 1988 DHS also found a significant unmet demand for family planning (of sexually active women at risk of becoming pregnant, nearly 55% indicated their willingness to use an efficient modern method of contraception during the two year period following the interview).

Waterborne diseases, poor hygiene and food contamination contribute to a high prevalence of intestinal parasites and diarrheal infections. Only 15% of the total rural population had access to sanitation facilities, and less than 50% to potable water in 1989 (WASH 1989).

Sexually transmitted diseases, including AIDS, seem to be increasing, but precise data are presently not available. Until very recently, the Government was sensitive about releasing information on AIDS. An evaluation on the implementation of the AIDS program was recently completed by a WHO team. The results of this evaluation show a definite progression of reported AIDS cases, but the seropositivity rate for certain target population groups still has not been released by the MOHP. The release of epidemiological data for AIDS and sexually transmitted diseases will be the critical element in defining future directions of the program.

The evolution of the AIDS epidemic has important implications for the health delivery system in Togo. Given what is already happening in other African countries, Togo will also be forced to treat increasing AIDS cases with its very little capacity or resources. If the virus spreads to women as it has in other African countries, the impact on infant and child mortality from mother to child transmission may become significant. Given the health system constraints already identified later in this document, the AIDS situation may soon be a major constraint to achieving further progress in improving the health status of the population. This will happen because limited resources will be pulled away from other priority child survival and public health programs to deal with AIDS.

C. Health Delivery Systems

(1) The Ministry of Health and Population

(a) Service Delivery

Persistent high mortality and morbidity levels, particularly in rural areas, led the Government to adopt a primary health care (PHC) policy with priority on improving peripheral services following the 1978 Alma Ata declaration on PHC. Since then, the Government has expanded and improved services and facilities throughout Togo, emphasizing maternal and child health. Presently UNICEF estimates that 60% of the population lives

within 5 kms. of a health facility, which for an African country, provides reasonable access to government health services.

The MOHP is the major provider of services in the health sector, operating 397 facilities throughout the country. Over the past 15 years Togo has approximately doubled the ratio of doctors and nurses in the public sector in relation to the number of people served.

The public health care system is staffed by 263 physicians, 64 pharmacists, 1,117 nurses, 843 midwives and auxiliaries, and 250 laboratory technicians. The physician/population ratio is 13/700, and the paramedical personnel/population ratio is 1/632. These ratios compare favorably with averages for sub-Saharan Africa (23/600 for physicians and 2/1000 for para-medical personnel) (IBRD 1990).

An inventory of public health care facilities reveals 365 health centers and dispensaries, 26 hospitals at the district (or prefectural) level, 5 regional hospitals, and 1 national referral hospital in Lomé. The World Bank also reports 1,914 health posts which are organized by individual communities. It is worth noting that the denomination of health facilities in Togo is contradictory, and needs to be standardized.

The distribution of public health care and family planning facilities, personnel, and financial resources is uneven and favors the coastal region, particularly Lomé (nearly 40% of personnel are located in Lomé and large towns).

(b) Pharmaceutical Distribution

Drugs in Togo are available through public, private and non-profit sources. The drug distribution system is operated by TogoPharma, a parastatal monopoly, which imports drugs for public and private facilities. Contraceptives are provided by donor agencies, primarily A.I.D. and the United Nations Fund for Population Assistance (UNFPA), and presently distributed by the Togolese National Family Planning Association (ATBEF). Other NGOs donate drugs to public and private organizations.

An intensive trade in illegally imported drugs exists throughout the country. The MOHP, through its own agency, PharmaPro, purchases a limited list of essential drugs from TogoPharma, which PharmaPro distributes to public health facilities. TogoPharma's infrastructure in rural areas consists of 8 pharmacies and 91 sales depots. There are 48 commercial private pharmacies in Togo, 73% of which are located in Lomé. These pharmacies are all supplied through TogoPharma.

(c) Health Care Financing

Togo's health care system is financed through the national budget, external donor financing, and private domestic funds. The 1990 GOT budget set by the Ministry of Finance contains a single allocation for the MOHP and the Ministry of Social Affairs

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and Women's Condition (MSAWC), since these two Ministries were combined until 1990. The recurrent cost budget for these two Ministries was US\$18.4 million in 1990, up from US\$17.0 million in 1989.

The GOT's recurrent cost budget for the MOHP is overburdened by staff salaries (nearly 80% in recent years), while allocations for non wage-related operating expenses account for the remaining 20% (A.I.D.-funded Health Sector Analysis). The 1990 investment budget set by the Ministry of Plan amounts to US\$3.7 million. In 1989, total GOT per capita spending on health amounted to US\$5.

Recurrent expenditures in recent years have represented as much as 95% of the total MOHP budget and are financed mostly by the GOT, while donors play a major role in financing investment expenditures. Particularly as a result of the financial crisis of the last few years, there has been a blurring between the recurrent and investment budgets. In some instances, the latter has also been used to finance staff salaries. The small portion of the budget going to support maintenance, repair, equipment, and other investment costs have led to a deteriorating infrastructure and low staff motivation, particularly at the lower levels of the system.

As MOHP administrative and financial systems are developed and improved, and public sector cost recovery systems are established under the TCSP, it is expected that in three to four years the MOHP will be able, once again, to assume an increasing burden of non-salary recurrent costs. This projection is based on the following: as resources are used more rationally and efficiently, additional resources should become available to cover these costs. Examples of these costs are fuel, repair and maintenance of equipment and supplies, printing costs, etc. In the meantime, bridge funding from donors will be required. The proposed project will provide some of this funding.

(d) Cost Recovery

At a regional meeting in Bamako in 1988, the African member states of UNICEF approved "The Bamako Initiative", a program designed to provide a mechanism for increased access of populations to essential drugs through a system of fees and cross-subsidies.

The GOT's Health and Social Sector Policy Statement and the Population and Health Sector Adjustment Program signed with the World Bank, both explicitly call for the design and implementation of public sector cost recovery systems for essential drugs involving nationwide user participation by 1993.

At the request of the MOHP, several donors are financing activities to assess (1) public and private health care use and expenditures, (2) the population's ability and willingness to pay for medicines and health services, (3) the real costs of health

care service delivery, and (4) the recurrent cost implications of alternative drug and medical supply distribution networks.

UNICEF, Geselleschaft für Technische Zusammenarbeit (GTZ) and the Fonds d'Aide et de Coopération (FAC) have provided assistance to establish pharmaceutical depots next to dispensaries and health centers where generic medicines ordered in bulk are sold. The prices for medicines are set by taking the cost of procurement and adding a margin to cover stock management and non-salary administrative costs at the health facility level.

In several villages there still exist health posts where a small number of essential medicines (usually 5-10) and basic primary care (first aid) are administered by a trained village health worker under the supervision of a health committee. In these communities a local midwife is also assigned to the village health post. Health agents receive 500-2,000 CFA per month through special village collections. While the intention was to locate village health posts in zones where populations live beyond 5 kilometers from a public sector dispensary (about 39% of people in the Central Region), many health posts are within a few kilometers of dispensaries. Medicines and medical supplies are paid for by health post clients, but basic consultations are free.

2) Private Sector

The health service related private sector has grown considerably in recent years, but most private clinics and pharmacies are located in Lomé. The private sector only accounts for about 5% of the total clinic personnel in Togo.

At least 20 private organizations work in the health sector. Most of them are religiously affiliated, and operate in large hospitals and many smaller health centers throughout the country. These facilities are often used by the population in preference to public facilities in the belief that they offer better quality care. These facilities are partially self sustaining through cost recovery systems which vary from one organization to the other.

ATBEF, a non-profit organization affiliated with the International Planned Parenthood Federation (IPPF), has played an important role in the development of family planning programs in Togo. With the support of A.I.D., it runs a family planning clinic in Lomé, distributes A.I.D. supplied contraceptives to public sector facilities around the country, supports community-based family planning motivators, and does much of the Information, Education, and Communication (IEC) for family planning in Togo.

Market sellers and street hawkers throughout Togo sell contraceptives (principally pills and condoms) and other drugs through the parallel economy, but the variety, quality, quantity, and prices vary widely.

3) Progress in Health Status

Togo has made major efforts to improve the health status of its population over the past fifteen years. The infant mortality rate has been cut approximately in half to a reported level of 80/1,000 for the period 1983-88. The child mortality rate has dropped to 158/1,000 over the same period.

The crude death rate has decreased to 14.1/1,000. These and other improvements to the overall health status of the population have resulted in the life expectancy at birth increasing to approximately 53 years (IBRD 1990).

In recent years the MOHP, supported by WHO, UNICEF and A.I.D., has significantly improved immunization coverage, and reoriented the malaria program's treatment policy to respond to changing conditions. Recent initiatives have been taken in growth monitoring, control of diarrheal diseases, maternal and child health and family planning. New concerns with AIDS and dracunculiasis (guinea worm) have been raised and are receiving donor support. Also receiving donor support is the promotion of community participation and health education efforts in a variety of programs.

The A.I.D.-funded CCCD program has assisted in improving the system of recording and reporting epidemiological data within the MOHP. However, the reliability of statistical data, the analysis of already collected data, and the use of data for improving management, all still need improvement.

D. Constraints to Health Delivery

Several sources of information on the Togo health sector were used in identifying constraints to better health and family planning service delivery. Among the most important were: A.I.D.'s 1990 Health Sector Analysis for Togo; the World Bank's 1991 Population and Health Sector Adjustment Program Project document; the GOT's 1990 document on the Health Sector presented by the Ministry of Plan in preparation for the World Bank-sponsored Donors' Conference in October 1990; OAR's presentation at the Donors' Conference; the 1989 Evaluations of the OAR's ACSI-CCCD, HSSCS, and FHI II projects; and UNDP's 1991 Overview of Donor Activities in Togo.

The GOT's own diagnosis (Ministry of Plan Health Sector Document) of constraints to improving the health status of Togolese mothers and children agrees with the above cited donor studies and evaluations with which they have collaborated. All sources agree that the MOHP suffers from the following major problems:

- inefficiencies in management and operating systems;
- poor quality provider-client interaction;
- MOHP staff training deficiencies;

- inadequate maintenance and repair of infrastructure;
- deficiencies in MOHP information management capacity;
- inadequate availability of medicines and supplies;
- weaknesses in supervision;
- inadequate public sector cost recovery system; and
- lack of private sector capacity outside Lomé.

1. Systems

The Ministry lacks an integrated information system to provide guidance and structure to planning, budgeting, monitoring, and evaluating both GOT and donor-supported activities. In the past, bottom up planning and budgeting exercises resulted in proposals for activities and expenditures that far exceeded budget constraints, resulting in general frustration when they were not funded.

Many individual MOHP program interventions are uncoordinated and place competing demands on field staff. Each is dependent on donors for non-salary recurrent cost inputs, provided through grants made to various divisions and services in the MOHP in Lomé (e.g., Epidemiology, Maternal and Child Health, Health Education, etc.).

Also, donor-created parallel support systems for separate interventions have weakened MOHP core support functions because of a verticalization of separate reporting systems, training programs, input distribution networks, and supervision. The internal dynamics of the MOHP together with institutional competition between ministerial divisions has encouraged such verticalization.

Initially, the problems in coordination posed by such verticalization were not considered as important as the fact that significant additional resources were being made available to support priority preventive health programs. More recently, both donors and senior MOHP officials have come to terms with the need to redirect external assistance so as to strengthen institutional capacities. This institutional strengthening will have a direct effect on improving program impact for beneficiaries by reducing or eliminating much of the duplication in the system.

Until the recent MOHP reorganization, there had been no specific unit charged with coordination, planning, budgeting, development of management information systems, staff training, research, and evaluation. In the new MOHP organizational chart a Directorate with these responsibilities has been created.

In the past, the MOHP has been required to procure drugs from the GOT-run monopoly, TogoPharma, which places a large mark-up on mainly brand name drugs. As part of the process, TogoPharma has

distributed the necessary drugs to peripheral MOHP facilities. The MOHP last year received permission to procure essential generic drugs directly through open competition. Such a process, assuming that TogoPharma is not the lowest bidder, will mean that the MOHP will not have access to the vehicles and systems for distributing drugs previously provided by TogoPharma. PharmaPro, the government agency, will have to pick up the slack.

2. Provider/Client Interaction

Service provision at the health facility level is presently constrained by very poor interactions between providers and clients. This is partly due to the low salaries of both medical and paramedical personnel, and thus low motivation to provide high quality services. Even more important, however, is the poor state of repair of MOHP facilities, and lack of necessary equipment, materials and supplies, all of which also lower staff morale and make it unlikely that quality services will be available. This problem is further compounded by a lack of training opportunities for lower level MOHP staff as discussed below. Finally, essential connections between the health facility and the community have been discouraged by an over-centralized administrative structure, again eroding staff morale.

3. Training

Health service training has been more closely related to donor-supported efforts than on-going institutional requirements. Donor programs have developed several small and separate groups of experienced and capable Togolese trainers in the MOHP whose skills and experiences are intervention specific. There is, however, a demonstrated need to articulate and develop linkages between the training programs associated with interventions in diarrheal disease control, nutrition, and growth monitoring; or family planning, AIDS, and safe motherhood.

In some cases training in technical areas has either not been done, been done poorly, or the wrong people were trained. For example, over 80% of the health facilities have no staff trained in clinical methods of family planning. Health workers have yet to develop skills in diarrheal disease control, and oral rehydration therapy to the extent they have for vaccination and malaria control.

Since there is no integrated management information system, there has been no training in this area, except in vertical record keeping and reporting systems imposed by donors for different interventions. Management and administrative training for medical and paramedical personnel is sorely needed, particularly since most of these personnel have received only technical training as part of their basic training, but their jobs contain significant portions of management responsibility.

No training has been provided for the repair and maintenance of facilities and most medical equipment, except for the maintenance of the cold chain provided with A.I.D. and UNICEF

assistance. Logistics training has been provided in support of the semi-autonomous parallel EPI and malaria program support systems while neglecting training for MOHP-wide motor pool management and pharmaceutical distribution.

The demonstrated abilities of most Togolese MOHP staff in using computer equipment suggests that little more than word processing training has been done effectively. As information systems are developed and improved, the need for computer training will become more critical.

4. Facilities, Equipment, and Vehicles

A good part of the facilities, equipment and vehicles essential to the functioning of a coordinated MOHP service delivery system is either lacking, un-inventoried, and/or in various states of disrepair. Approximately half of the prefectures are believed to have either no microscopes, or the ones they have are not operational. The infant, child, and maternal mortality rates are believed to be seriously aggravated by untreated anemia, while none of the prefectures have photometers to diagnose anemia. The availability of intra-uterine device (IUD) insertion kits in health facilities outside of Lomé is extremely limited.

In prefectoral medical facilities with functioning microscopes, their use together with that of other miscellaneous laboratory equipment is hindered by the lack of glass slides, chemicals, papers, and other necessary consumable inputs.

Vehicles in the field are not inventoried, and their state of repair and remaining useable life is unknown. The MOHP garage in Lomé, managed by a health worker (with no motor pool or motor repair experience or training) has no tow truck and lacks the ability to service vehicles assigned to the field. The vehicles, coming from a variety of donors, are of varying brands, requiring different tools, training, and spare parts inventories.

Vehicles previously provided by donors were assigned to individual division chiefs, according to specific interventions. These vehicles often have no vehicle logs, or gas consumption or repair and maintenance records, thus making estimates of their remaining useable life, and the timing of replacement decisions, difficult or impossible.

PharmaPro, which will soon take over pharmaceutical distribution from TogoPharma, has no heavy duty trucks or all-terrain vehicles suitable to the assignment. The central ministry offices responsible for program coordination and management, e.g., the Direction Générale, the new Directorate of Planning and Staff Training, and the Directorate of Administrative Affairs, have no vehicles to monitor and supervise activities outside of Lomé.

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5. Information Management

Computers provided to the National Health Statistics Service (SNSS) for the production of the Annual Health Statistics report, are largely not being used to manage a national data base. Except for use of the EPI-INFO software in SNSS, and some other sub-sets of data elsewhere in the MOHP, information is largely entered and manipulated by staff from the CCCD project, and is not managed by MOHP staff.

Togolese staff continue to rely upon raw data from paper records, tabulated with mechanical desk top calculators. The resulting statistics are then entered into the computers using word processing software, and printed out as the final report. The SNSS group has only recently issued a request for local bids for repair and maintenance of hardware, after three years of sending a hardware specialist every six months from Atlanta to tend to the equipment.

No computers exist in peripheral facilities. The prefectures did not receive feedback on 1990 health statistics until July 1991. While this represents a considerable improvement over experience in years prior to 1989, additional improvements are necessary. Few photocopiers exist in prefectural health offices, which in conjunction with no word processing or data base management capacity, puts a heavy administrative burden on Chief Medical Officers and their staff. It is estimated that approximately 50% of the time of peripheral health personnel is spent filling out forms required by Lomé, many of which are duplicative.

6. Medicine and Contraceptives

The MOHP remains dependent on the vaccines and malaria prophylactics it receives through the ACSI-CCCD Project. There are insufficient GOT cash reserves and inadequate MOHP budget resources to sustain current activities once the CCCD project ends.

The chloroquine supplies provided through CCCD are calculated on the basis of requirements for children under five and for pregnant women. Once supplies are distributed, however, they are issued on an as needed basis to a much larger population. This results in stock outages often as early as two weeks after the arrival at the prefectural level of the twice yearly drug shipments. To ensure adequate supplies of chloroquine for women and children, sufficient chloroquine for all users must be made available by the system. The MOHP is unable to provide sufficient supplies due to budgetary constraints.

Contraceptive distribution networks remain underdeveloped and un-integrated into MOHP systems. Both PharmaPro and the Division of Administration and Finance do not have the capacity to calculate contraceptive needs. The MOHP accounting and SNSS health statistics systems collect no information on family planning or the distribution and use of contraceptives. Current supplies are provided by international donors, principally A.I.D.

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7. Supervision

Among the first items to be eliminated in the non-salary recurrent cost budget squeeze were fuel and vehicle maintenance. Supervisors at all levels are handicapped by the very limited capacity to visit, monitor, train and provide feedback to the health workers over which they have supervisory line responsibility. The Directeur Général rarely sees any of the Prefectoral Chief Medical Officers, except when they come into Lomé. The Prefectoral Chief Medical Officers rarely meet with the heads of the health facilities in their prefecture, except when they visit the prefectoral capital to receive salary payments or during the periodic vaccination drives ("Action Vaccination"). In addition, integrated supervisory protocols to encourage supervisors at all levels in this particular functional responsibility have not been developed.

8. Cost Recovery

Village health posts are increasingly encountering difficulty in remaining financially viable and have fallen out of favor with donor agencies, although not with the MOHP itself. Whether in the UNICEF or GTZ zones of activity, village health posts have particular difficulty providing the salaries of the health agents and midwives. GTZ, UNICEF and the French Volontaires du Progrès are now turning their attention to the creation of dispensary and health center pharmacy depots with cost recovery schemes. The schemes are aimed at covering most non-salary recurrent costs of these public-sector facilities.

9. Obstacles to Private Sector Development

The health sector also suffers from a lack of accessible and affordable private sector channels for delivering health and family planning products and services, especially in rural areas. The lack of standardized credentialling mechanisms, and medical standards appropriate to each grade of health professional makes the government reluctant to approve non-physicians as private practitioners.

Public sector medical Assistants, nurses and midwives are known to practice outside government hours in Lomé, and non-licensed pharmaceutical vendors operate throughout the country. The MOHP is unable to monitor their activities, and is uncertain of whether the net result of these semi-tolerated activities is positive (expansion of the availability of health care) or negative (un-monitored malpractice performed by unqualified para-professionals).

There exists, as well, a pool of qualified and experienced unemployed health professionals. This pool, in large measure, is a reflection of the MOHP's limited financial capacity to extend employment, and the lack of start-up capital to finance the establishment of private practice. The pool includes an undetermined number of doctors, nurses and medical assistants straight out of basic training schools as well as over 200

experienced health workers removed from MOHP rolls as a result of budget cuts in recent years.

E. Government of Togo Policies, Programs, and Actions

1. MOHP Core Budget Support

The 1991 MOHP core program budget received from the Government provides for approximately US\$25 million, 80% of which covers salaries, and the remaining 20% non-salary recurrent costs. An investment budget of approximately US\$1.1 million is funded by donors.

The GOT-funded non-salary recurrent cost budget for the MOHP provides modest amounts of credits to each prefectural chief medical officer for a) vehicle fuel, lubricants and repairs; b) office supplies; c) small facilities repairs and maintenance, and d) miscellaneous medicines. These credits are drawn down by submitting bills or pro-forma invoices to the accounts clerk in the office of the Prefect. In addition, each chief medical officer submits an annual pharmaceutical budget to Lomé, with shipments made twice yearly in January and July.

The pharmaceuticals received are generally consumed within six to eight weeks of each shipment, and the credits are so modest as to force nearly every chief medical officer to personally subsidize repairs, supplies and fuel costs.

2. The Vaccination Program (EPI)

The MOHP's Expanded Program of Immunization (EPI), with technical and financial assistance from A.I.D., UNICEF, WHO, GTZ, CUSO, and others, has followed a strategy of daily immunizations at every health facility, combined with periodic national campaigns to increase coverage.

Daily immunizations at each peripheral public health facility have been possible following the extension of the cold chain to 100% of the facilities. The MOHP has also adopted a policy of reducing the chances of "missed opportunities" for vaccination, meaning that any unvaccinated child is vaccinated any time he or she is identified by the system, even if the child did not come to the health facility for vaccination. This results in a certain amount of vaccine wastage when vials are opened for just one shot, but WHO, CDC, and A.I.D. studies have concluded that the cost of wasted vaccine is considerably less expensive than the social and economic cost of the "missed opportunity".

Periodic campaigns called "Action Vaccination" were conducted with mobile out-reach teams before the fixed site vaccination program was functioning in 100% of the health facilities. The MOHP is currently weighing the costs and benefits of such campaigns, given that they require pulling staff away from other key functions in MOHP facilities for as much as a month at a time, two to three times per year.

Since 1985, the MOHP has permitted health facilities to sell vaccination cards and retain the money for local use. The cards are small cardboard printed formats for recording immunizations. The fees collected do not cover the costs of the immunization program. So far, the funds thus collected have not been separately accounted for to the central Ministry, but were intended to provide a petty cash fund for each facility, especially to cover the cost of repair and maintenance of the cold chain (e.g., to buy kerosene and replacement wicks).

3. Malaria and Diarrheal Disease Control Programs

In Togo, malaria and diarrheal disease-related problems account for the largest portion of maternal and child mortality and morbidity. Established control programs to combat these health problems have not been as successful as the EPI Program described above. This is due principally to the emergence of a chloroquine-resistant strain of malaria and difficulties in changing maternal behavior towards diarrheal disease. Vaccine development and conservation represent difficult technical challenges to resolve. Even more challenging are successful control programs that are dependent on only a limited number of more easily managed contacts with the health system than what is necessary for malaria and diarrheal disease control.

In 1987 the MOHP detected, before WHO or other donors, the spread of chloroquine resistant malaria in Togo. As a result, it changed the recommended treatment protocols, increasing the standard dosages, and discouraging the premature and routine use of high dosage chloroquine injections which should be reserved as a last resort.

The MOHP is developing the capacity, principally in Lomé, to conduct research to determine more precisely the cause of the marked increase in the spread of malaria in Togo. New microscopes provided under the CCCD project for the National Malaria Control program have aided this effort.

With regard to diarrheal disease control, an MOHP policy of establishing Oral Rehydration Therapy (ORT) teams at each peripheral health facility has been in place since 1988. These facilities were to have as their model an "ORT Corner" established at the Centre Hospitalier Universitaire (CHU) in Lomé. The staffs have been trained throughout the country, and the ORT packets have been distributed. Some community training has been done in the preparation of home solution recipes, while reinforcing traditional recipes where appropriate.

The ORT Corners are not functional, however, in most health facilities. The oral rehydration salt (ORS) packets are being used for cases treated at the facilities but have not found wide use in the home. It is believed that this is due to the inadequacy of the training received by the health workers who appear to have an insufficient appreciation of ORT as an intervention, and do not promote it as a home treatment.

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4. Family Planning Policy

Since 1986 and with A.I.D. assistance, the GOT has issued several studies concerning population growth and family planning in Togo. A national report which did not have the weight of official policy was issued in 1987 endorsing family planning. In 1990 the MOHP prepared official guidelines for use in promoting family planning at MOHP health facilities. With World Bank assistance, the MOHP continued the analysis and discussion of the issue, resulting in 1991 in a formal national policy statement endorsing family planning.

Based on this policy statement, the MOHP has committed itself to a broader national expansion of family planning products and services. In 1990, 10% of MOHP facilities offered family planning services; in 1991, 16% provide family planning, and the eventual target is 100% coverage. The MOHP envisions to increase the range of clinical services by training nurses in methods counseling IUD insertion and prescription of oral contraceptives. Currently only midwives have been trained in IUD insertion, and most of those who have are based in Lomé.

5. Cost Recovery Policy and Program

Five years of successful experience with the sale of vaccination cards as a pilot cost recovery effort led the GOT in 1990 to authorize legal retention and reprogramming of locally-generated revenues at each public health facility. Larger scale cost recovery programs, however, require a functioning MOHP accounting system reaching down to the dispensary level. The MOHP currently has contracted a local accounting firm to design and install such a system. The implementation of this new accounting system will be required by the World Bank prior to releasing any funds under its new sectoral adjustment program.

The new legislation authorizing cost recovery was based on the "Bamako Initiative" promoting the sale of essential drugs at the village level. The MOHP has taken the spirit of that initiative and expanded upon it. The MOHP-issued list of essential drugs comprises not only the 30 specified on the UNICEF list but also 210 generic medicines including preventive items such as anti-hypertensives and oral contraceptives. The MOHP also proposes that cost recovery eventually be expanded to include fees for consultations and laboratory services. Such fees would be either flat charges for services or pre-payment schemes covering an episode of illness or a fixed time period (e.g., a month or a trimester).

In preparing its sector strategy for the World Bank Population and Health Sector Adjustment Program, the MOHP proposed a system of cost recovery designed to cover all costs associated with the purchase and distribution of essential medicines. The system also comprises a margin destined to subsidize partial costs of the primary health care delivery facility where the medicines would be dispensed.

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The GOT issued decree No. 01/91 signed on January 3, 1991, recognizing the existence of a number of already functioning cost recovery committees in the Maritime and Central Regions. The decree authorizes local management committees at the level of each facility to introduce cost recovery, manage funds and use proceeds for replenishing stocks of essential drugs and financing critical non-wage operating expenses. The decree specifies that the pricing strategy should provide for 80% of revenues to cover the costs of replenishing stocks, and 20% to cover administrative expenses at the facility level (i.e., equivalent to a 25% mark up).

Based on studies from other countries, an ad-hoc MOHP committee on cost recovery determined that a 110% mark-up over the import price of some 160 generic essential drugs should be envisaged. In addition, a further 90% mark-up was proposed to cover the cost of service delivery in the health facilities. A final protocol listing some 27 common ailments with required medicines, dosages, and fees by age category of patient (newborn, child, adult) was developed. The ad-hoc committee has yet to make a formal report on the policies and systems that it proposes for cost recovery.

There remain large areas of the country to be covered by a basic cost recovery system. Also, discrepancies exist between regions on the final form of price lists and the role and composition of local management committees. Finally, there remains a need for MOHP guidance in promoting nationally a uniform cost recovery policy with specified parameters for local initiatives in setting prices for services and medicines.

The current system at work is intended to establish the necessary organizational and financial structures and procedures to ensure (a) the timely and effective delivery of medicines at all facilities, as needed; (b) the pricing of medicines at a level adequate to replenish stocks as well as cover certain other additional costs; and (c) the control and tracking of funds.

6. Health Sector Restructuring

After extensive policy dialogue on the subject with the World Bank, the GOT envisions a comprehensive restructuring of the MOHP in support of improved service delivery. The key elements of the restructuring are: a) decentralization of management; b) horizontal integration of programs; c) MOHP budget adjustments; and c) expansion of family planning, and private sector health services.

The MOHP budget adjustments include (a) reducing personnel expenditures from 80% of recurrent costs in 1990 to 75% in 1994, and (b) increasing the GOT funded investment budget for the MOHP to 5% of the MOHP total in 1994. Within the framework of the World Bank Sector Adjustment Program, the GOT is also committed to increase the percentage the MOHP receives of the national budget from 5.1% in 1990 to 7.5% in 1994.

7. Collaboration with the Private Sector

In November 1990, the MOHP and a private medical association, "Amicale des Médecins Privés", jointly sponsored a conference on the involvement of the private sector in health delivery services. The participants included professional groups representing doctors, pharmacists, veterinarians, laboratory technicians, and others involved with private sector health activities.

The conference, undertaken without donor involvement, expressed a consensus among public and private sector health professionals that their common interests require cooperation. The conference participants recommended that: (a) illnesses identified by, and services provided at, private health facilities be included in the MOHP Annual Health Statistics Report; (b) MOHP accrediting standards for doctors and other para-professional groups be established; and (c) medical procedures appropriate to the different grades of accredited health professionals be codified.

The "Amicale des Médecins Privés" is interested in finding ways to help unemployed doctors begin private practices, especially in secondary cities outside of Lomé and in rural areas. The Amicale has also prepared a draft for discussion with the MOHP proposing a mandatory pricing regime for all doctors, with precise fees specified in a 100-page guide for every sort of medical consultation or procedure imaginable.

The MOHP, for its part, has expressed an interest in encouraging the expansion of private health practitioners, and ensuring quality controls and professional standards, without resorting to price controls or other market interventions.

F. Other Donor Assistance

1. World Bank - Health Sector Restructuring

To assist in restructuring the health sector in Togo, the World Bank has agreed to provide IDA credits of US\$14.1 million for the period 1991-1994. The credits are issued as program assistance, to be released in tranches tied to a list of 17 specific administrative and policy reforms.

Restructuring steps already taken include: (a) reorganizing the MOHP into five new directorates, one of which will be directly responsible for overall coordination, planning, staff training, and budgeting; (b) approving a national population policy; (c) establishing the administrative mechanisms necessary for a national public sector cost recovery policy; and (d) naming appropriately qualified candidates to key positions in the reorganized MOHP.

The release of credits for the first tranche is awaiting three steps: (a) World Bank approval of the candidates for Directors of the five new directorates; (b) installation of an approved MOHP accounting and financial management system reaching down to

the dispensary level; and, (c) installation of an approved MOHP procurement and contract management system.

The MOHP and the World Bank have identified 17 policy reform measures to address the fundamental constraints to improving primary health care and family planning in Togo. Moreover, they have agreed upon them as conditionalities for the release of credits. Measures 10 and 13 extensively address the issues pertaining to health service cost recovery and community participation. Measure 10, Mobilization of additional resources for sector operations, states that:

the Government proposes to introduce cost recovery in all public health facilities. To develop this system, the Government proposes, under the Program, to design and implement cost recovery measures and an essential drugs program in a sample of facilities during 1991-92 and to generalize the system in all centers by 1994.

Measure 13, Development of sustainable essential drugs procurement and cost recovery systems, is concerned with promoting "efficient procedures for the procurement, distribution and management of essential drugs supplies." The decentralized management of this system involving "community participation through facility level management committees" is reiterated. Distribution systems to be created by the Government to ensure adequate supplies of "basic generic drugs" to all health facilities are to be "linked to the cost recovery system and would mobilize domestic funds for financing critical non salary operating costs which the budget cannot fully finance."

There are two underlying justifications for the involvement of representatives of beneficiary committees in the management of local stocks and funds. Such involvement will help to stimulate increased community activity in primary health care and to rationalize the use of household expenditures for health care.

2. Gesellschaft für Technische Zusammenarbeit (GTZ)

The German organization for technical cooperation, GTZ, assists the MOHP in two areas with two pilot projects: (a) one supports a new clinic management system at the Maternité de Bé in Lomé which integrates medical interventions horizontally; and (b) the other supports a cost recovery program in the Central Region, with long-term technical assistance team based in Sokode.

In the past year, GTZ has established 12 functioning Village Pharmacies (VPs) in the Central Region. Prior to project activities in the zone, village groups were already organizing among themselves to buy medicines from TogoPharma outlets and resell them at a profit in their home villages. Now with generic drugs supplied by GTZ at much lower costs than those provided by TogoPharma, the system will be much more likely to be sustainable. GTZ also works with health committees drawn from the larger community development committees (CVDs).

GJK

The GTZ pilot project in the Central Region has been innovative and aggressive in collecting more complete baseline data, and developing additional forms and reports for clinical services, accounting, and inventory and distribution of medicines. The pricing strategy GTZ is following is based upon a 200% mark-up on generic medicines. Even with this mark-up, generic drugs are available to villagers at a price which is still below that of the TogoPharma brand name medicines.

GTZ is joining with the FAC in an effort to extend the cost recovery system to all dispensaries and health centers in two regions by the end of 1994. French assistance will fund cost recovery system for the Plateau Region, and GTZ will continue its assistance in the Central Region. GTZ has committed US\$4 million to continue these activities within the framework of the MOHP Health Sector Restructuring Program for the period 1991-1994.

3. UNICEF

UNICEF has collaborated closely with the MOHP on (a) the EPI program; (b) the Diarrheal Disease Control Program; and (c) the program of cost recovery from the sale of essential drugs. For the EPI, UNICEF has provided vaccines, sterilizers for needles, other vaccination material, and support for staff training; for diarrheal disease control, they have provided, and will continue to provide, all of the ORS packets distributed through the MOHP and support for training; for cost recovery, UNICEF has assisted an MOHP ad-hoc committee to develop a decentralized record keeping system for the sale of 30 essential drugs, using the Bamako Initiative model.

With UNICEF assistance the MOHP created 21 village pharmacies in late 1990 in the Vo and Zio prefectures of the Maritime Region of Togo. An initiative has also been launched to extend, with UNICEF assistance, a cost recovery system to an additional 36 dispensaries in the Savanes, Plateau and Maritime Regions by the end of 1991.

UNICEF plans to eventually extend its coverage to the Kara Region. When all donor efforts are included, it is envisioned that village pharmacies will be created in 80% of all peripheral public health facilities. The number of dispensaries covered is expected to reach 295 in the three regions by the end of 1994, with 68 village pharmacies established in 1992, 102 in 1993, and a final 68 in 1994.

The methodology proposed by UNICEF to extend the principles of the Bamako Initiative to the rural areas of Togo focuses on the establishment of depots of 30 essential medicines at or near dispensaries to be managed by local Village Development Committees (CVDs). In some cases, where these do not exist, the MOHP has established Village Health Committees.

UNICEF anticipates close cooperation between the Prefectoral Training and Supervisory team and local CVDs. Six persons are included in the prefectoral team: the Médecin-Chef, the Medical

Assistant (MA), the principal Midwife; the Social Affairs Sector Chief, the Coordinator for the Health Education Service (SHES), and where possible, a doctor from the Regional Hospital.

Finally, the UNICEF cost recovery system will have to be reconciled with the GTZ model. Neither of these addresses the full scope of MOHP goals for cost recovery from the sale of generic drugs as well as clinical and laboratory services.

4. "Volontaires du Progrès"

Local CVD's and health sub-committees had already existed in many villages from about 1983 to 1987 through efforts of the French "Volontaires du Progrès". All of these early efforts at developing sustainable village pharmacies had become bankrupt by 1987 due to credit sales, inadequate cash control and inappropriate pricing strategies. By 1989, the "Volontaires du Progrès" began again in different villages with revised strategies to address these shortcomings. This second round of experience is proving to be more successful.

5. A.I.D. Regional Projects

In addition to the three bilateral projects (CCCD, HSSCS, and FHI-II), A.I.D. has provided and will continue to provide short term technical assistance through regional and centrally-funded projects. These are (a) the Service Expansion and Support Project (SEATS), (b) the Social Marketing SOMARC and OPTIONS, (c) INTRAH, (d) DHS, and (e) Health Financing and Sustainability. Under the first five of these projects, assistance has been provided to the MOHP in the area of population and family planning. A brief needs assessment survey has been conducted under the sixth, with a view to offering future assistance in cost recovery.

Assistance from these projects to date has been of great service to the MOHP, but the manner in which it has been offered has been uncoordinated. This problem will be addressed directly under the TCSP.

G. A.I.D. Program Strategy

A.I.D. recently elevated Togo to the status of a Category I Mission. This decision was made as a result of Togo's satisfactory progress in implementing its structural adjustment program described in Section A above, as well as the recent advances in democratic initiatives and political reform taken by the GOT. In the light of this changed status, additional documentation must be prepared in support of an increase in the bilateral assistance program to Togo.

Therefore, the OAR's overall assistance strategy for Togo is currently under review. OAR's first Country Program Strategic Plan (CPSP) will be developed early in fiscal year 1992. In preparation for this long-term strategic plan, OAR has over the last year gathered all available information on its present major

sectors of intervention, including child survival and population. Analysis of existing data, including the work of other donors and the GOT provides an excellent picture of the status of the health sector. The major documents consulted are presented in the introductory paragraph of Section D above.

As a result of these existing rich sources of information, OAR has already defined an assistance strategy for the health sector. Preliminary work to develop a program goal and strategic objectives for the medium term is complete. The TCSP project is designed within the framework of OAR's articulated goal and strategic objectives.

OAR has defined its overall Program Goal as "improving the quality of life by helping achieve broad-based, market oriented, sustainable economic growth, better health, and increased democratic participation in the development process". Within this goal, four strategic objectives have been identified to date. These are:

- (1) improve maternal and child health status;
- (2) increase the use of modern contraceptives;
- (3) increase the level of savings through credit unions;
- (4) increase net exports of manufactured products and traditional agricultural crops.

OAR developed the strategic objectives for the health and population sector from the previous analytical work referred to above. Of particular importance has been the development of the Government's Population and Health Sector Adjustment Program with the World Bank.

The present project will address the first two of the strategic objectives outlined above. It combines the Mission's existing three separate child survival and population projects into one management entity with the aim of focussing OAR's efforts in the sector. It will also build on lessons learned from past experience. The design of the project also responds to recent guidance from Washington which encourages OAR to (a) concentrate in fewer sectors; (b) focus on problems where A.I.D. can make a difference; (c) design for results which will ensure people-level impact; and (d) ensure that necessary management and information systems are in place to assure and measure results.

The strategy of the TCSP project is to focus on the improvement of management and administrative systems within the MOHP which will directly affect the delivery of child survival services at peripheral levels. The focus is on institution building and sustainability, two important developmental processes which have proven weak in previous A.I.D. projects in the sector, as further discussed below. The project also responds to key institutional weaknesses identified in the development of the World Bank's sector program, and provides assistance in addressing these weaknesses. The chances of success of such a project have markedly improved recently due to political reforms and the signature of the Sector Reform Program with the World Bank.

The Development Fund for Africa (DFA) defines four key strategic objectives for the Africa Bureau. The first calls for improving African economies by redefining and reducing the role of the public sector and increasing its efficiency. The present project is designed to support this Africa Bureau objective in three key ways.

First, it focusses on improving management and administration of the MOHP, a key government public sector entity. Management improvements are of crucial importance in a Ministry run by physicians, with little or no training in administration, and a traditional bias towards curative as opposed to preventive care. The present technical leadership of the MOHP in the person of the Director General increasingly has recognized over the last year that this area is key to the future development of the sector.

Second, the project encourages the expansion of private sector health care to areas outside of Lome where almost all of the present private sector capacity is concentrated. The Ministry also has decided recently that it needs to expand its contacts and association with the private sector to achieve its own goals of promoting improved health in Togo.

In a related development, the project will support MOHP plans to expand cost recovery systems in the public sector. This will encourage community participation in paying for and managing local health care resources. It will also make it possible for the public sector to augment Government resources to provide necessary drugs, materials, equipment and supplies to improve and provide better quality public services.

Finally, the project's emphasis on planning and efficient management will support Strategic Objective One (Target 1-3) of the DFA by encouraging the use of public monies to provide public goods efficiently and equitably. The Government has demonstrably increased its commitment to the health sector. It cannot afford to waste the limited resources available from both internal and external sources on ill-defined, uncoordinated programs. The improvement of internal MOHP support systems, such as information collection and analysis, supervision, drug distribution, will all receive attention under the new project.

In the area of population, the DFA Action Plan emphasizes strengthening the expansion of both public and private family planning services through policy development, training, and information, education and communication (IEC) development. This project will support the continued expansion of family planning service provision, particularly outside of Lome. It will promote the expansion of the present community-based distribution system for contraceptives in the private sector. It will also establish a contraceptive social marketing program in both the public and private sectors. Finally, it will support continued IEC development through the local family planning PVO, ATBEF.

In addition, the DFA Action Plan calls for a strengthening and broadening of A.I.D.-supported activities in health and child survival. This would include (1) health financing, particularly cost-recovery, as part of an overall sustainability strategy; (2) strengthening management to assure sustained, effective provision of services; and (3) development of national systems of data collection, collaboration and analysis. The proposed project with its emphasis on planning, information systems development, management, supervision, integration of services to improve service delivery, and health financing includes these DFA target activities as central project components.

H. Lessons Learned and Linkages to Past A.I.D. Projects

OAR has had bilateral health projects in Togo since 1980. For the purpose of this analysis, the lessons learned from four major projects, three of which are still ongoing, are considered. For these four projects there still exists institutional memory through both documents and personal experience at the Mission and within the Government. The four projects are as follows:

-- Togo Rural Water Supply and Sanitation (RWSS: 693-0210); 1980-1987; Funding: \$10.75 million. The RWSS final evaluation was performed in December, 1987. The principal objectives of the project were to improve the health of rural inhabitants through the prevention of water-borne diseases and those related to the lack of sanitation; to reduce infant mortality from diarrhea and dehydration; to improve the nutritional status of children under five; and to extend the responsibility of villagers in pump maintenance, sanitation and community development.

-- Combatting Childhood Communicable Diseases (CCCD: 698-0421.02); 1983-1992; Funding: \$2.5 million. This project's last external evaluation was performed in September, 1989. The project supports the vaccination program, the malaria and diarrheal disease control programs, and health information system improvements with training, equipment and technical assistance.

-- Health Sector Support for Child Survival (HSSCS: 693-0228); 1987-1992; Funding: \$5.5 million; The mid-term external evaluation was held in August, 1989, with a follow-up in January, 1990; Objectives of the project are to strengthen planning, coordination and budgeting for child survival activities at the central level; improve health education and training in peripheral health facilities for child survival; and support community outreach for promotion of child survival techniques.

-- Family Health Initiatives II Project (FHI II: 698-0462.93) 1987-1992; Funding \$1.5 million; A mid-term evaluation was held in May, 1989. The project's objectives are to enhance the freedom of individuals in Togo to voluntarily choose the number and spacing of their children, and to encourage a rate of population growth consistent with the growth of economic progress in Togo.

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There were two additional earlier family planning support projects, Togo Family Health (1977-1985; \$1.3 million), and the Family Planning International Assistance Togo 02 (1983-1986; \$0.2 million). Comments on these two projects are not included in this section because the FHI II activity encompasses the lessons learned.

The following presentation is a synthesis of lessons learned from these projects based on the problems identified and recommendations made in evaluation reports, and OAR's own implementation experience.

1) Build on and work through existing GOT institutional structures

The RWSS project worked through existing Government structures. Although the project had initial difficulty in coordinating the different organizational entities, in the end the evaluation team found that the decision to work within the system had been a sound one for long term sustainability and consensus building.

The CCCD project has, from the beginning, been physically located directly within the MOHP's Division of Epidemiology. As such, it benefitted from the direct access to the Ministry this location brings. This was done even though one of the components of the project, diarrheal disease control, does not fall under the direct responsibility of this Division. The overall advantage of integrating into an existing structure has outweighed the inconvenience of not having all project activities under the control of one Director.

The HSSCS project was never totally integrated into the MOHP structure as a result of design complications and initial implementation confusions. The Planning and Coordination Unit (PCU) of the project was not a ministry unit prior to the project, and was created by the project with personnel drawn from other government structures.

The task of the PCU was made more difficult initially because the importance of the planning function was not recognized by senior MOHP management personnel early in the project, but its institutional separation from official MOHP structures made it much harder to be accepted and prove its value to the Ministry.

Now that the MOHP has been reorganized and a Directorate of Planning and Training created, the Ministry has recognized the importance of planning within its organization. The creation of this Directorate, coupled with the present lack of planning and coordination capacity as a major constraint to efficient use of resources, led OAR to choose the Directorate of Planning and Training as the focus of central level project support in the new project. Of critical importance to the success of the project will be the staffing of this new Directorate. The experience of the existing HSSCS planning and coordination unit will provide the foundation for planning in the new Directorate. Recent

results in the HSSCS project also suggest that the idea is finally taking hold.

2) Weak supervision

Both the direct service delivery support projects, CCCD and FHI II, identified lack of supervision as a major constraint to improved services. The quality of services delivered in the health facilities depends to a large extent on the motivation and interest of the health personnel staffing them. Because of the lack of training, the non-availability of standardized supervisory protocols, overworked chief medical officers, and the lack of resources for transport, supervision is very weak at the prefectoral level.

These evaluation findings, coupled with the recognized need for decentralization and integration, led OAR to propose support for creating a multi-functional public health support team at the prefectoral level. A prefectoral team headed by the chief medical officer will make more health personnel available to train, supervise, and carry out necessary administrative and technical tasks.

The creation of multi-functional teams should be coupled with additional resources to be made available to the prefectures in support of field transportation costs, as well as materials and equipment to improve service quality.

3) Connecting the planning function with field activities is important

The evaluation of the HSSCS project confirmed that its design had been appropriate in combining planning and field activities, so that planning would not be cut off from the realities of the field. However, it was also noted that project personnel at the central level had difficulty focussing on the planning function when field level activities were programmed. Personnel tended to focus on field activities to the detriment of planning. OAR proposes to continue with a planning focus at the central level (particularly through the creation of an integrated management system), but to target support for field activities directly to the prefectures.

To improve central and field planning as well as support direct field interventions, OAR suggests the following: Local cost financing for improving supervision and materials to support priority child survival programs should be made available to prefectoral health teams according to established planning criteria. These criteria are to be articulated during project implementation. Increased resources will be made available to those prefectures which prove that they can plan effectively according to guidelines set in place by the central Ministry. The procedures would be the same as those required by the GOT in setting its own budget, so that the improved planning at the periphery could eventually also lead to increased resources from the Government budget.

4) Inefficient movement of money provided directly by A.I.D. through REDSO/WCA/WAAC delay project implementation

Local cost expenditures in both the FHI II and CCCD projects are processed through the OAR and the West Africa Accounting Center (WAAC) at REDSO/WCA. Evaluations of these projects identified the procedures for the receipt and liquidation of advances as impediments to the timely availability of money in the field. The HSSCS project provides local currency through a contractor, making money available on a more flexible and timely basis in response to changing needs. OAR proposes to use the same mechanism in the new project initially while improved administration and financial systems are developed. These systems will be developed by the MOHP with the assistance of contractor technical assistance personnel. Once developed, the project will make financing available directly to the MOHP.

5) More attention needed for development of management systems

The CCCD project evaluation found that the project had made significant progress in certain technical areas such as vaccination, malaria control and health statistics reporting, but that key areas important for institution building and sustainability had been overlooked. In particular, it singled out management and financial systems development as important areas for further work.

The CCCD project as presently implemented has shown its potential for achieving short term impact, but the question still remains whether this impact will be sustainable without additional management emphasis. For example, the vaccination program with massive inputs from the donors has had impressive results, but now that those development resources have been spent and results achieved, can the Government absorb the program into its regular management structure?

This question, combined with the need for more program integration, led OAR to propose that the new project emphasize the creation of an integrated management information system. This system will contain elements of the present health statistics system, and personnel, logistics, and financial information together in one place for planning and management. This will be an institution building process which should enable the Ministry to better manage the resources it does receive.

An additional handicap of the Planning and Coordination Unit of the HSSCS project was found to be its lack of basic data and information on which to base planning decisions. Under the MOHP reorganization, the present Health Statistics office will move under the authority of the new Planning and Staff Training Directorate. Therefore, the follow-on planning support proposed should be much improved over the present configuration.

Finally, it has been noted in the FHI II and CCCD projects that much information is collected routinely, but often little of it is processed, analyzed and examined to determine its validity or

its usefulness for decision making. This is connected to the issue of fragmentation in that vertical programs all require their own data. The situation is worst at the peripheral health facilities where the same person must collate all the data every month for all these different programs. This finding also supports OAR's decision to encourage the development of an integrated information system for the MOHP.

6) Improved integration/coordination needed

Donors tend to exacerbate fragmentation of programs according to their traditional way of programming money. USAID is no exception, and in the health and population sector OAR has seen the difficulties with separate project activity in the three ongoing projects it manages. These three projects are "housed" in three separate Ministry structures, with different project counterparts and different organizational loyalties. Project directors tend to guard information and monopolize resources rather than share and cooperate with each other. It is with this constraint in mind that the new project is integrated into one overall activity focussed in the new Directorate of Planning and Staff Training. This should avoid duplication of effort, and avoid some of the breakdowns of communication experienced under the three separate projects.

III. PROJECT DESCRIPTION

A. OVERVIEW AND STRATEGY

1. Overview

During the past ten years the GOT's ability to financially sustain previous levels of public health services has declined. This has been matched by a gradual increase of donor assistance, reaching near parity with Government expenditures in the early 1990s. Donor assistance has typically taken the form of targeted project assistance, generally aimed at strengthening a particular vertical intervention (e.g., immunizations, malaria control, or family planning). The point of entry for such assistance has generally been at the technical division level of the MOHP (e.g., Division of Epidemiology, Division of Maternal and Child Health, etc.).

As the number of donors and the volume of activities and funding increased, problems of coordination appeared, especially at the prefectural and health facility levels. Nearly all donor projects provided vehicles, equipment, medicines, supplies, and financing for local expenditures. These inputs were managed outside of routine MOHP administrative channels. The result was a weakening of central Ministry functions and authority, making eventual institutionalization and sustainability of donor supported activities unlikely.

Senior MOHP officials acknowledge they have given mixed signals as to their preferences regarding donor assistance. They recognize the problems of coordination and integration posed, but also are keenly aware of the need for additional resources. Within the MOHP the Chiefs of technical divisions argue that the ultimate beneficiaries, Togolese women and children, receive greater impact from programs that are run semi-autonomously within the overall MOHP structure.

Recently, MOHP senior management and donors realized that the proliferation of non-integrated projects, creating parallel, separate administrative and support structures, are not only costly, but managerially less effective. Currently a single aggressive project coordinator can use donor resources to draw field staff away from priority MOHP functions and other donor activities to support the donor activity of his division. While the resulting impact figures look good in the short term, in the long term, the overall MOHP program suffers.

A lack of program coordination and integration also yields a lower impact for beneficiaries, due to unnecessary duplication and compartmentalization of training, paperwork, and supervision. The interrelatedness of technical program interventions may not be addressed during staff training (e.g., connections between malaria and anemia; CDD, nutrition and growth monitoring; safe motherhood and family planning; etc.). The results of this lack of coordination show most clearly at the service delivery level

during actual clinical consultations, often leading to poor quality services.

Senior MOHP management has requested that donors join with them in devising new ways to channel assistance, so as to strengthen the Ministry's ability to manage its own service delivery programs. At the same time the GOT has also agreed to increase the MOHP budget by a fixed amount (400 million CFA) each year indefinitely beginning in 1992.

These expected budgetary increases figure into a calculated effort to plan for absorbing the recurrent costs of current donor activities, once they come to an end. The MOHP believes, however, that the GOT alone cannot support the increasing demand for health and family planning products and services. It accepts that the private sector must be tapped as a resource to complement GOT services, and that increased community participation in local level cost recovery systems will also be required to meet future needs.

2. Strategy

The proposed project has been designed to avoid the weakness of past projects which provided inputs to specific organizational units within the MOHP in support of vertically oriented programs. This approach was, in some cases, successful in achieving results in specific technical areas, but has proven weak in improving overall MOHP institutional capacity and sustainability. A strategic consideration in the development of this project, therefore, is the importance of improving MOHP capacity and sustainability. At the end of the project, the MOHP will be better able to manage its own systems without continued external technical assistance.

The proposed project should be so well integrated into MOHP structures that it is nearly invisible as a project. The long-term technical advisors will be located physically in the MOHP in offices alongside their counterparts. While the emphasis will be on improving MOHP institutional capacities, beneficiary impact will be achieved through increased efficiency, and improvements in the quality of service delivery as a result of management improvements.

The process is deliberately one of phased withdrawal, with intensive A.I.D. assistance during the first three years, followed by the withdrawal of most long-term technical advisors at the end of the third year. Project supported subsidies for certain non-salary recurrent cost inputs (budgeted at 50% for LOP) will be disbursed on a declining scale (e.g., 100% PY1; 80% PY2; 60% PY3; 40% PY4; 20% PY5; and zero PY6). This schedule requires that the MOHP fully assume budgetary responsibility for recurrent costs one year before project completion.

An additional aspect of overall project strategy will be the provision of direct A.I.D. financial and technical assistance to prefectural and lower administrative levels. This is a departure

from previous OAR experience where most project resources were directed to central level structures. OAR explicitly seeks to support the MOHP policy of decentralization.

Experience has shown that central level support has not had the desired impact on long term improvement of service delivery systems, or ultimately on the health of intended beneficiaries. Long-term technical assistance under the project will remain at the central level to help establish the improved systems and provide training to MOHP counterparts. However, mechanisms will be established by the project to allow and encourage materials, equipment and financial resources as appropriate to directly reach the prefectoral level.

An important assumption underlying this strategy is OAR's conviction that additional encouragement and support at the level of the Chief Medical Officers in the prefectures will have a direct impact on service delivery. Control mechanisms must be established to ensure that resources are being used appropriately. This is exactly what the development of improved management and administrative systems is intended to provide.

If improved standards and criteria for the planning and allocation of resources can be established at the central level, then resources must be made available at the prefectoral level for implementing the changed procedures. This will provide important motivation for the prefectoral level teams and below, after so many years of over-centralized management and critical shortages of resources. If the prefectoral teams accept the improved planning procedures, it will also improve the likelihood that they will continue to receive increased GOT resources because their regular feedback will have been institutionalized within MOHP planning systems.

At the health facility level, service providers are poorly motivated. This contributes to low quality provider-client interaction as described in Section II D above. Management improvements, cost recovery, and training at this level will all have a direct impact on this critical constraint.

Improved and increased supervision will affect service quality and also improve personnel motivation. The cost recovery component will generate additional resources to increase the availability of essential drugs and other materials and supplies. This will also lead to better quality services and greater provider motivation and client satisfaction. Additional training opportunities at the lower levels will have the same effect. The ultimate effect of all these improvements will be reflected in improved health indicators, particularly for women and children, the specific target beneficiaries for the project.

Assistance to the private sector will be focussed on removing policy or administrative obstacles to the expansion of product and service delivery networks, and increasing opportunities for financial and technical assistance for opening new private sector facilities. Such assistance will be provided in close

collaboration with the MOHP to ensure professional standards are respected in pursuit of a wider range of accessible and affordable services.

Preparations will begin early for an eventual transition to non-project assistance. The design of a complementary non-project assistance together with the requisite analyses will begin during the first year of implementation of the TCSP. It is expected that institutional capacities will be developed sufficiently during the first three years so that the MOHP will be capable of managing A.I.D. provided resources with only short-term technical assistance during Project years four through six. It is envisioned that subsequently, project assistance can be completely replaced with either budgetary, or non-project assistance, as intermediate steps to total MOHP self-reliance.

B. OBJECTIVES

1. Goal

The goal of the project is to increase life expectancy and reduce the population growth rate, leading to an improvement in the health status of the population of Togo.

Goal level achievement will be measured by standard maternal and child health indicators such as maternal, infant, and child mortality and fertility projections based on census and DHS data. Achievement of the project goal will contribute to achievement of OAR's overall program goal as discussed in Section II G above. While this project is not the only factor affecting eventual goal achievement, it is expected that the project will have an impact on the health status of beneficiaries over the six-year period.

2. Purpose

The purpose of the project is to decrease infant, child and maternal morbidity and mortality, and increase contraceptive prevalence.

The achievement of the project purpose is based on the assumption that improved MOHP management and administrative systems will have a direct impact on better quality service delivery. The reasoning behind this assumption is laid out in detail in the preceding section. The present project will concentrate on the issues of institutionalization and decentralization. Direct impact on beneficiaries will be achieved through the expected improvements in service delivery.

Within the project's framework, child survival programs are defined as vaccination, diarrheal disease control, malaria control, nutrition, maternal health, family planning, and AIDS control. Since the project seeks to encourage integration of services, separate project components in these areas have not been explicitly defined. Project-provided technical assistance, commodities, and training will cover any of these areas in the

context of the proposed improved planning system to be established and following the strategy discussed above to provide more resources directly to peripheral levels.

3. End Of Project Status

The project will establish the following targets as indicators for achievement of the project purpose.

(a) Health management information system for MOHP developed and implemented in all 30 prefectures by 1994. System will include health statistics, program-related, personnel, logistics, and financial information;

(b) Integrated system to collect information on technical program-related interventions developed and implemented by the central statistics office by 1994;

(c) Information on the private sector included in GOT annual health statistics by 1995;

(d) Standard treatment and drug utilization protocols developed and implemented for priority child survival interventions by 1994;

(e) Integrated supervisory protocols based on the above standard treatment and drug protocols developed and implemented for prefectural level supervision by 1994;

(f) Public sector cost recovery system developed and established in all 397 health facilities by 1997 based on sales of essential drugs, contraceptives, and consultation fees, where appropriate;

(g) Functioning Village Development Committees established by 1996 in the 397 communities where public health facilities are located. These committees will control local facilities for quality of care, and manage the local currency fund generated by the cost recovery system;

(h) 30 multi-purpose prefectural public health teams trained and providing technical, administrative, training, and supervisory support in each prefecture by 1996;

(i) The full range of modern family planning services offered in 60% of MOHP public health facilities by 1997; 80% will offer all methods except the IUD, and 100% will offer non-medical family planning methods;

(j) 30 prefectural teams trained and submitting annual work plans and budgets by September of each year for the following year's Government budget submission. All teams will be trained by 1995;

(k) MOHP guidelines for professional standards, and criteria for different categories of health personnel to open private health care facilities approved by GOT by 1995;

(l) Essential drug list by category of health facility approved by MOHP, and essential drugs being distributed at least quarterly to all health facilities by 1997;

(m) Twenty-five new private sector health facilities established outside of Lome by 1997. These facilities may be managed by physicians or other para-professional personnel according to standards to be established by the MOHP;

(n) Contraceptive prevalence rate increased from 3% to 12% for modern methods;

4. Outputs

The following outputs will be achieved by the project by 1997:

- * 25% reduction achieved in anemia of pregnant women;
- * 75% reduction achieved in reported cases of neonatal tetanus;
- * 35% reduction in reported cases of diarrheal diseases;
- * 90% of pregnant women receive prenatal care;
- * 80% of birth deliveries are attended by qualified personnel;
- * 90% of women who give birth in MOHP facilities receive tetanus toxoid #2;
- * 80% of children aged 12-23 months immunized by antigen;
- * 50% of children under 5 are growth monitored;
- * 50% of children under 5 with diarrhea receive ORT;
- * Condom use increased to 10% in populations with multiple sex partners;
- * Quarterly reports on AIDS cases and seropositivity in established sentinel groups published by MOHP;
- * Yearly sales of condoms through the social marketing program reaches 3,000,000;

5. Inputs

To achieve the outputs of the Togo Child Survival and Population project the following types of inputs will be provided by A.I.D and by the Government of Togo (host-country contribution):

- * 360 person-months of long term technical assistance placed in key divisions of the MOHP. There will be a total of seven long-term technical assistance advisors, in residence for periods ranging from 24 months for the Health Trainer to 60 months for the Chief of Party and his or her Project Administrator (local hire). A second locally-hired Financial Advisor will support the Facilities Management/Logistics Specialist in developing management and cost recovery systems for the MOHP over 36 months. An MIS Specialist/Programmer and a Private Sector Health Specialist also for 36 months complete the list of specialized long-term technical assistance.
- * 37 person-months of short-term technical assistance during the life-of-project divided among six types of related professional expertise.
- * Buy-ins, PASAs, and contracts represent a substantial portion of project funds (\$2,930,000), and will involve, in all likelihood, significant participation of at least nine already identified centrally-funded A.I.D. projects or other government agencies (e.g., CDC).
- * Long-term participant training is an important input to the TCSP project. Seven key high-level cadres from the MOHP will each receive 30 person-months of education in U.S. graduate programs, such as the MPH and MPA.
- * Short-term participant training will generate approximately 50 person-months of specialized skills building. A total of 12 types of training programs have already been identified and costed, and additional provision made for presently unidentified targets of opportunity.
- * In-country training workshops will be extensively used during the life of the TCSP project. Some 21 different workshops have already been identified and budgeted, and additional unprogrammed resources identified to respond to other presently unidentified requests.
- * Operations research and special studies are expected to be frequent under the project. Some of the potential data needs already identified are:

- Private Health Care Mapping Exercise
- Family Planning Social Marketing
- Causes of Malaria Increase in Togo
- Food Self-sufficiency and Nutrition
- Health Marketing Survey
- Effects of Malaria on Anemia and Malnutrition
- Causes of Chronic Malnutrition

- * Commodities constitute the largest component of the TCSP project (23%). Some 23 different types of commodity inputs will be delivered to the MOHP or to ATBEF (\$30,000). Major commodity types are vehicles (7), computers and printers (33), photocopiers (25), and medicines. Contraceptives constitute the largest single cost item among commodity inputs (\$1,620,000). During the final years of the project the MOHP will need to assume the recurrent costs of medicines and other essential supplies and fuel. Rather than an abrupt transition, a gradual phase-down of USAID support for new costs is envisaged in the Implementation and Financial Plans.
- * Host-country contributions total 26% of total project costs, thus meeting the A.I.D. requirement for the level of host country financial participation. This input component consists of the salaries of the MOHP personnel at all levels when involved with project activities, the non-salary recurrent costs which must be assumed in a phase-in over the last years of the TCSP, and the amount of local currency to be generated through the cost recovery component of the project.

6. Beneficiaries

Numerous individuals and groups will benefit from the successful implementation of this project and the spread effects of its activities. Primary beneficiaries are the approximately 725,000 women of reproductive age (15-49) and the approximately 600,000 children aged 0-4 years who will receive better primary health care services as a result of the project.

Staff of the MOHP who will be trained will also be primary beneficiaries through the improvement of their on-the-job skills, which in turn will lead to better performance of their work. The MOHP as an institution will benefit through the programmed administrative and management improvements. The integrated health management system will improve the management capacity of health workers at all levels. These health workers will improve and extend the quality of health services. Health workers and officials will gain skills in information collection, reporting and analysis, decision making and problem solving, supervisory techniques, pedagogic methods, and IEC techniques. Through the health financing cost recovery activities, they will learn accounting and financial management skills as well as program budgeting techniques.

Individual private sector health practitioners as well as their associations, also stand to benefit through the implementation of the loan program to help them establish their practices. They will also benefit from the technical knowledge which will be provided by the private sector technical assistance expert.

The national scope of project activities will therefore help lessen regional as well as urban /rural inequalities in the

delivery of health services. A sustainable health delivery system will benefit all groups, and is a strong instrument of a well-functioning democratic country.

C. PROJECT COMPONENTS

The project is divided into four components. They are (1) the improved management of the MOHP and the expansion of a health cost recovery program; (2) the strengthening of integrated and decentralized health and family planning service delivery; (3) the promotion of public and private sector collaboration in the health sector; and (4) the strengthening of private sector health and family planning delivery capacity. The four components are outlined below.

(1) Component One: Improving MOHP Management and Expanding the Public Sector Health and Family Planning Cost Recovery System:

The first component of the TCSP will comprise the following:

- 1) establishing a functioning Directorate of Planning and Staff Training;
- 2) improving the Directorate of Finance and Administration's capability to provide personnel management, financial services, and logistical support;
- 3) assisting the Prefectoral Chief Medical Officers to better manage their resources and supervise the health facilities within their prefectures;
- 4) simplifying and integrating the existing health statistics and management information systems, while improving local health facility staff ability to plan and manage their own resources; and,
- 5) developing MOHP capacity to distribute essential drugs and medical supplies to all levels.

The process of implementing the above objectives requires that the MOHP develop a clear, shared definition of its own policy, standards and guidelines, and the development of a comprehensive integrated management information system. The process of developing a comprehensive integrated management information system and clear standards will serve as a tool in integrating child survival, maternal health, and family planning services. Decentralized decision-making and supervision, and improved coordination will be accomplished through the process of developing an integrated management information system.

(i). Assistance to the MOHP central office in Lome:

Direction of Planning, and Staff Training

This project component will assist the MOHP in the establishment of a central Directorate of Planning, and Staff Training as

agreed under a Ministry reorganization plan signed with the World Bank.

Division of Planning and Programming

The component will provide assistance to the Planning and Programming Service to implement a consensus-building process to develop a health information system. This will permit a better integration of health service delivery and improving effectiveness and efficiency.

A committee, consisting of central level directors, Chief Medical Officers, health facility level staff, and representatives from major donors, private health practitioners, and non-profit groups providing health services will identify the information needs of the management system and determine the means of collecting such information. Another committee will be organized to refine the standard classification system for health facilities to include services provided, drug list and personnel, equipment, and space requirements. Other committees will develop standards and protocols for the diagnosing and treatment of diseases and prescription and use of drugs.

Project assistance to the Directorate of Planning and Staff Training will strengthen its ability to:

- identify service, personnel and infrastructure needs and to prepare program and project proposals for funding by the Ministries of Plan and Finance, and/or donors, using their new information system;
- evaluate donor project proposals, integrate donor projects into existing MOHP programs, and monitor the impact of program and project interventions;
- conduct management and medical/technical studies by the Studies and Research Service through involvement in the Demographic and Health Survey, the National Census and subsequent studies to develop the management information system, and to improve health delivery systems.

Division of Statistics

The project will help the Statistical Division strengthen its role as the central source for data collected by the Health Statistics and the Management Information systems. Through the development of quarterly reports, improvements to the annual health statistics yearbook, and by an enhanced ability to respond to specific requests from the Director General and other divisions, this Division will provide the statistical information needed by the MOHP for improved management of health delivery. This will include the continued collection and analysis of epidemiological data on morbidity and mortality, and analysis of this data which will be used for improving program targeting and planning.

This Division will also be prepared to serve as a resource for the MOHP in resolving computer related problems within the Ministry. This will include developing the Division's capacity for processing of data collected by the Studies and Research Service. The Division will be encouraged to work with other Ministries to coordinate data collection efforts and exchange relevant data.

The Statistical Division will be responsible for working with the MIS committee to refine the monthly reporting system. Monthly reports presently submitted by public health facilities will be condensed into one report designed to supply the preventive, curative, and management information needs of Chief Medical Officers and Central Directorates. The monthly reporting base will be expanded to include reports from the private and non-profit sectors, as well as reports from other Ministries which provide health services (e.g., Ministry of Social Affairs, Defense).

Collecting and maintaining baseline data needed for the management system, in addition to the monthly reports data, will be another responsibility of this Division. Essential baseline data needed would include, but not be limited to, an inventory of health facilities and health personnel, population data for each facility, lists of CVDs, number and condition of medical/technical equipment, and vehicle inventory. Preparation of a series of maps showing all health facilities and their zones of responsibility will be an additional task for this Division.

The Statistical Division will develop systems for presenting data in timely and usable formats. They will publish a statistical yearbook, quarterly summaries of monthly reports, and be responsible for the design, printing and distribution of monthly report forms. This Division will develop guidelines and standards for computer usage within the MOHP. The guidelines will include equipment and software standards, data base coding, computer usage, training requirements, backup strategies, and maintenance and repair standards.

Division of Staff Training

The Project will help the Staff Training Division develop a system for coordination of training programs proposed by other Directorates and donors. The Division will maintain a records system for tracking personnel medical, technical and management training. The Training Division will work with existing medical schools training medical assistants, nurses, and midwives to refine existing curricula and develop a new course on the monthly reporting system.

The Training Division will develop in-service training and a users manual for the monthly reporting system. Workshops on how to collect and report data and how to use data for better management will be conducted at the prefecture level for health facility managers and at the central level for chief medical officers and central directors. They will also prepare the CVD

training curriculum for financial and stock control systems under the cost recovery program. Working with the Statistics Division, the Training Division will organize computer training courses and write simple instruction manuals for use by MOHP computer users.

Finally, the project will assist in the establishment of a documentation center at the central level. The documentation center will collect, classify, and maintain all major documents produced by the health sector as well as related documents from other ministries and outside sources.

Directorate of Common Affairs (Administration and Finance)

The reorganization plan renames the Division of Administrative Services and Finance as the Directorate of Common Affairs, and creates an administrative division and a finance division within that Directorate. The Project will work with this division to improve its administrative and financial management capabilities as described below:

Division of Personnel Management

The Project will assist the Division to computerize its personnel management system, train personnel to use system, and develop methods for up-dating the system on a regular basis. The proposed decentralization of personnel management will require close collaboration between this Division and the Chief Medical Officers and the development of management systems at the prefectural level.

Although the Infrastructure and Maintenance Service is located under the Finance Division, administrative systems for this service need to be developed. A motor pool control and maintenance program will be created under this component. Once the MOHP motor pool is made functional, all A.I.D. provided vehicles (from the TCSP and previous projects) will be placed under the management of a unified motor pool manager. The motor pool management team will also become an integrated part of the pharmaceutical distribution team along with PharmaPro, and the Division of Finance. As part of its rounds in the field transporting personnel, and pharmaceutical, the motor pool staff will also provide routine supervision and oversight on the use, repair and maintenance of all vehicles assigned to the field.

Similar programs will be developed for repair and maintenance of MOHP buildings and for repair and maintenance of medical and technical equipment. Training in medical/technical equipment maintenance will also be included in this project.

Division of Finance

The World Bank Health and Population Sector adjustment loan has created a new financial system for investment and recurrent budgets at Central and Prefectural levels. The Project will

assist the Finance Division in implementing the system and monitoring the cost-recovery component.

The decision to allow the MOHP to purchase essential drugs directly from the suppliers (instead of through TogoPharma) will require the development of the Finance Division's capacity to prepare orders under international bidding procedures.

Directorate of Pharmacies, Laboratories,
and Technical Equipment

Implementation of the cost-recovery system will require the development of a reliable drug delivery system. This project will help the MOHP to establish the management and control of such a system.

(ii) Assistance to the MOHP Prefectoral Level Offices:

Prefectoral Headquarters

The project will work with the Chief Medical Officers to reduce their management burden while giving them greater control over the health activities in their Prefectures. The improved monthly reporting system, increased availability of demographic and management data, standardized management systems and training will improve the Chief Medical Officers' capacity to manage their Prefectures. Medical Assistants will be trained to assume some of the administrative duties of the Chief Medical Officers.

A supervisory checklist and instruction manual will be developed to include medical/technical issues as well as financial, personnel and logistical management concerns. The checklist will be developed by the Chief Medical Officers using MOHP medical/technical and management standards and guidelines. Supervisory teams will be formed and trained to assume some of the supervision at the prefectoral level. (See project component 2 below for more details on prefectoral- level assistance.)

Once all revised manual information systems are in place, computers will be installed in each prefecture (that meets readiness criteria established by the Director General on advice from the Directorate of Common Affairs), and staff trained in the use of data entry and output reports. The installation of computers will facilitate the chief medical officers' capacity to respond to medical and management problems in an accurate and timely fashion, while reducing the time needed to supervise their prefectures.

Local Health Facility Level

The monthly reporting burden will be reduced with the installation of a revised reporting system. The head of each health facility will be trained in using the monthly reports as a management tool, and in financial and inventory control for the cost-recovery system.

(iii) Assistance for Implementation of a Public Sector Cost Recovery System:

This part of Component One will assist the MOHP in expanding and consolidating its initial pilot experiences in cost recovery. Based on the spirit of the Bamako Initiative, the MOHP aims at a more ambitious program of cost recovery that goes beyond the sale of a short-list of essential drugs at village pharmacies.

Policy Development

The cost-recovery portion of this component will be based on a uniform national policy and implementation schedule for cost recovery in health care soon to be developed.

At first, the project will help the MOHP phase in a pharmaceutical sales program at the prefectoral level from the health centers to the local dispensaries. As the system becomes operational, it will be expanded to charging for consultation and other medical services, including laboratory tests from both MOHP patients, and for referrals from the private sector practitioners. Revenues generated will be used to replenish stocks of items sold and basic non-salary inputs to services provided. Any excess revenue after covering costs will be retained and reprogrammed by each local health facility to improve the range and quality of health services. This component will provide intensive start-up assistance to help the MOHP launch a pharmaceutical procurement, distribution and sales network.

The Project will help the MOHP integrate the various pieces of technical assistance from different donors to assure that they are complementary and consistent with the MOHP's strategy for cost recovery. The cost recovery policy will also address and resolve discrepancies existing between the various pilot experiences. Principally, the national policy will extend a uniform cost recovery system with clearly defined parameters for local initiatives in setting prices for services and medicines.

Pharmaceutical Distribution

Assistance will be provided, under the Project, to the Directorate of Pharmacies and Laboratories (Pharmapro) and the Directorate of Common Affairs (Division of Finance, Facilities and Equipment Maintenance Service, and the MOHP Motorpool). This is to ensure the proper functioning of a demand-driven, efficient, effective, and timely pharmaceutical distribution system. The support anticipates heightened demand for generic drugs from the pharmaceutical depots and village pharmacies caused by the drug sales as described above.

This will require:

- establishing a procurement and contract management system (see below);
- reinforcing initial inventories at PharmaPro in Lomé;

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- establishing a nationwide distribution control system including controls for timely ordering and delivery; controls on waste, fraud, and abuse; and, screening of expired drugs at each phase of distribution;
- establishing a functioning MOHP motor pool under the Directorate of Common Affairs, including heavy trucks and appropriate technology for sustaining a cold chain for vaccine distribution;
- reinforcing warehousing capacity, including repair and maintenance in Lomé and at certain field level sub-centers (Regional or Prefectoral capitals) for temporary warehousing and redistribution;
- training local staff (MOHP employees and/or CVD health personnel) in bookkeeping and inventory management and control (see below);

Financial Management

(a) Procurement: The Directorate of Common Affairs will receive assistance in establishing a procurement function, (bidding, contracting, contract management, etc.) consistent with MOHP and A.I.D. rules and regulations. This will involve reviewing and revising systems, training staff in the Division of Finance, and establishing functioning cooperative relationships between the Division of Finance and PharmaPro. The Division of Finance and the various field offices from which revenues must return to Lomé to pay for replenishment of stocks will similarly be involved.

(b) Cost Accounting and Pricing Strategies: The cost recovery component will ensure that the MOHP has financial management systems that allow for the determination of full costs for products and services which the MOHP may contemplate selling. In order to determine pricing, the MOHP (at all levels, down to the CVD) should also have the capacity to determine the ability and willingness of local households to pay for a given product or service.

(c) Cash Control: The cost recovery technical assistance will verify and ensure that the bookkeeping and cash control systems from Lomé down to the local dispensary and CVD levels are functioning appropriately. This will involve developing a cadre of MOHP bookkeeping advisors who can serve as long-term, in-house advisors to local health facilities and CVDs. This function will become part of the duties of one of the existing members of the prefectoral teams led by the Chief Medical Officers (tentatively identified as the Medical Assistants).

Community Development

Under the project, the MOHP will be provided assistance in developing and strengthening the CVD health sub-committees. A management committee at the level of each health facility will

be established, composed of MOHP health personnel and members of the village development committees.

The project will assist the MOHP in providing training courses for key members of all 400 health facility management committees. Such training should be to help the local committee to plan and implement cost recovery programs using new and official MOHP materials (perhaps based upon, but no longer identified with, the pilot activities of the donors).

The project will help the MOHP provide the following training:

- financial management and accounting for the medical assistants and the health committee treasurer; and,
- stock control and logistics for the inventory clerk and the personnel responsible for the maintenance of the cold chain refrigerator.

ILLUSTRATIVE INPUTS

Inputs to this component consist of long and short-term Technical Assistance, buy-ins and PASA arrangements, training, commodities, and support for studies and research.

(a). Long-Term Technical Assistance:

- (1) Health Planner and Manager/Chief of Party (60 months)
- (2). Administrative Assistant (60 months)
- (3). Management Information Systems Advisor (36 months)
- (4). Health Trainer (24 months)
- (5). Facilities Manager/Logistics Specialist (36 months)
- (6). Financial Management Advisor (36 months)
- (7). Private Sector Health Specialist (36 months)

(b). Short-Term Technical Assistance

- Private Sector Oversight (6 person-months)

Assistance will be provided to the Division of Private Facilities in developing regulatory mechanisms for private sector drug importation, wholesaling, and retailing (pharmacies, and non-licensed pharmaceutical vendors). The objective is to assist in the removal of expired and harmful drugs from the market, and increasing tariffs on harmless but useless products, while reducing tariffs on essential generic drugs.

- Operations Research in management or Technical areas (6 person-months)

Management/Technical Research assistance will be provided the Division of Planning for research planning, operations and research logistics, analysis of data, and on-the-job training of Studies and Research Service personnel.

Five major operational research studies will be funded under this project. Research topics will be determined by the needs of the project. Possible topics include the following: Private Sector Mapping, family planning Social Marketing, Causes of Malaria Increase, Food Self-reliance and Nutrition, Health Marketing Survey, Effects of Malaria on Anemia and Malnutrition, Causes of Chronic Diarrhea.

- Training (12 person-months)

Technical Trainer assistance will be available under the project to assist in the conduct of in-service managerial and medical-technical training.

- Library Science/Documentalist (6 person-months)

Short-term assistance will be provided for a specialist to assist in setting up a Document Center within the Training Division. He/she will make an initial visit in the second year of the project with follow-up visits in years 3 and 4. Equipment necessary for establishing a documentation center will be included in the project.

- Health Education Planner (2 person-months)

As a follow-up to health education assistance already provided under the existing HSSCS and CCCD projects, additional assistance in this area will be provided. Of particular importance will be assistance to the newly formed Division of Staff Training to rationalize in-service training in technical and management areas as well as help for the newly formed Service of I.E.C. (the old National Health Education Service - CNES).

- Nutrition Planner (5 person-months)

Given the importance of nutrition-related morbidity and mortality in Togo, and the lack of progress in this area in existing projects, nutrition will be given special attention in the new project. In this regard, technical assistance in planning or technical areas of nutrition will be provided.

(c). Long-term Participant Training

- Master's Degree in Health Management (two years)

Upon the return of the Director of the Division of Planning, the Director of the Directorate of Planning, Training, and Personnel

Management will be sent to the United States for a two-year master's Degree program in Health Management, specializing in Planning.

- Master's Degree in Information Systems Management (two years)

The Director of the Division of Health Statistics will be sent to the United States to be trained in management of information systems. This will be of particular importance due to the emphasis in the project on integrating information systems and avoiding continued use of parallel information systems for all vertical programs. During his absence he will be replaced by the Director of the Statistics Service, who will have received short-term training in the meantime.

- Master's Degree in Health Statistics (two years)

The head of the Studies and Research Service will be sent to the United States for a two-year Master's Degree program in Health Statistics. The program will emphasize analysis of health statistics and computerized statistical programs. Summer work experience in a health statistics office will be included in this program.

- Master's Degree in Health Administration and Logistics (two years)

The Director of the Division of Administration will be sent to the United States to be trained in Health Administration with emphasis on facilities mapping, inventory control, motor pool management, and planning for and managing the repair and maintenance of health infrastructure and technical equipment.

- Master's Degree in Training Program Management (two years)

The Director of the Division of Health Training in the Directorate of Planning, Training, and Personnel Management will be sent to the United States for a two-year Master's Degree program in the Management of Health Training and Human Resource Development Programs.

- Master's Degree in Epidemiology (two years)

The Director of the Division of Epidemiology will be sent to the United States to pursue a formal degree in epidemiology. This is of particular importance due to the present lack of interpretation of routine health information and lack of analysis of the annual health statistics report.

- Master's Degree in Health Economics and Finance (two years)

The Director of the Division of Finance will be sent to the United States to study health finance and economics. This will

provide the Ministry with the necessary expertise to coordinate the national cost recovery system which will be established over the next few years. It will also help the Ministry respond more rationally to the need to better utilize existing resources, and argue for the MOHP in the annual GOT budget exercise.

(d). Short-Term Participant Training

This programmed training will for the most part be in french, either in the United States or in third countries. It will not be the strategy of the project to train participants in english prior to undertaking short term training. There now exist sufficient french language courses in all areas outlined below, that additional english training will not be necessary.

- Repair and Maintenance of Medical Equipment (6 months)

Three months of training each for two technicians is planned for the project. They will be provided with highly intensive training in a variety of brands of equipment to match the equipment in Togo which come from many different sources (primarily because of different donor contributions). Tools and equipment will be provided for the trainees upon their return from training.

- Short-term Training in Information Systems Management (4 months)

The Head of the Statistics Service in the Division of Health Statistics will be sent to the United States for a one-month course in health statistics. Upon his return he will be named acting director of the Division of Health Statistics. Three additional months of training have been included over the rest of the project, due to the emphasis on this area.

- Managing Drug Supply for Primary Health Care (4 months)

The Director of Pharmapro (Pharmacien Chef) will receive a one-month course in the United States which will emphasize a systems approach to the selection, procurement, use, and distribution of pharmaceuticals. Also, an additional three months of training have been included due to the emphasis on Bamako Initiative cost recovery systems development.

- Financial Management for Health (3 months)

The Director of the Division of Finance will receive a three-month course in the United States on planning, budgeting, budget management, cost accounting, and pricing strategy for public health. The Financial Management Advisor will work with the Director of the Division of Finance to apply his training to the needs of the MOHP.

- IEC Materials Development (4 months)

The Director of the new Service of Information, Education and Communication (old SNES) will receive a one-month course on communication techniques, and other members of his staff will receive similar appropriate training.

- Child Survival/MCH Technical Training (6 months)

Central or Prefectoral level MOHP staff will receive appropriate technical training depending on the needs identified during the course of the project. This will complement the management training already provided.

- Short-term training in Health Management (2 months)

The Director of the Division of Planning will be sent to the United States for a one-month course in the Management of Primary Health Care. Upon his return he will be named acting Director of the Directorate of Planning and Staff Training.

- Nutrition and Primary Health Care (2 months)

Technical training in nutrition will be provided to appropriate staff in support of the increased emphasis on nutrition. Emphasis will be placed on integrating nutrition interventions into the ongoing service delivery system.

- Technical Training in Family Planning (3 months)

With the present low rate of contraceptive use in Togo, the project will be concentrating on expanding family planning services as quickly as possible. In support of this effort, appropriate MOHP and private sector providers will be provided with short term training as necessary.

- Cost Recovery Field Visits (2 months)

Under the project, assistance for two teams of three persons each will be provided to examine working primary health care cost recovery systems. The teams will be composed of representatives from the MOHP/Division of Finance, Pharmapro, ATBEF, and selected Chief Medical Officers.

- Motor Pool Management (2 months)

A six-month course will be provided to the head of MOHP motor pool. Upon his return he will conduct an in-service training course for the MOHP drivers on safe vehicle operation, vehicle log record keeping, and operation and maintenance of vehicles.

- Drug Supply Logistics (2 months)

A senior level person from Pharmapro, other than the Director (Pharmacien Chef), will receive six months of training in the logistics of demand-driven pharmaceutical distribution, including cold chain management.

(e). In-Country Training (Workshops)

In-service training programs for MOHP personnel at the prefecture level will include the following:

- (1). Financial Management for Health

The Medical Assistants from each prefecture will receive training in the understanding and use of the new MOHP cost recovery, accounting and financial management policies, materials and procedures. The Directorate of Planning and Training personnel will be assisted by consultants and the financial management advisor in conducting the course. The initial course will be for two weeks in year two of the project with a follow-up course in year four.

- (2). Training of Trainers in Planning and Budgeting

Chief Medical Officers and Medical Assistants from each of the prefectures will be trained in the conduct of planning and training work sessions. The Training team from the Training Division will conduct the training with the assistance of project technical advisors.

- (3). Planning and Budgeting Seminars (Prefectoral Level)

Heads of health facilities in each prefecture will use MOHP technical and policy guidelines to develop an integrated plan and budget of health service delivery for the upcoming year. Trained chief medical officers and medical assistants will serve as facilitator for this exercise.

- (4). Planning and Budgeting Seminar (National Level)

The chief medical officers from each prefecture together with the central level directors will jointly develop a national plan and budget for health service delivery for the upcoming year. MOHP trainers and project technical advisors will facilitate this seminar.

- (5). Facilities Record Keeping and Management (National Level)

The chief medical officers and medical assistants from each prefecture and central directors will be introduced to the revised monthly reporting system. They will be trained in record keeping procedures and monthly reporting. They will also receive

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training in the use of the reports for better management of the health services in their respective prefectures.

- (6). Facilities Record Keeping and Management
(Prefectoral Level)

The heads of public and private sector health facilities will be introduced to the revised monthly reporting system. They will be trained in record keeping procedures and monthly reporting. They will also receive training in the use of the reports for better management of the health services in their respective prefectures. A training team from the Directorate of Planning and Training will be assisted by the chief medical officers and medical assistants in conducting the course.

- (7). Operation of the Computer/Health Information
System (Prefectoral level)

Once the information system is developed and computers are ready for installation, prefectoral level personnel will receive training in how to use the computers and the information system. A follow-up course will be taught six months after introduction of the computer in the prefectures. Statistical Division computer personnel will teach the course with assistance from the Training Division.

- (8). Medical and Technical Training Modules

As a support to integration of service delivery, the project will finance the training of medical and paramedical personnel in specific technical areas related to child survival. Three basic cycles will be developed into training modules based on diagnostic and treatment protocols to be developed by the MOHP. These cycles are described in the next section on the second component of the project.

- (9). Management and Technical Supervision

The training team from the Directorate of Planning will train supervisory teams in each prefecture in supervisory techniques including the use of a supervisory checklist on their inspection and training visits to the health facilities.

- (10). Bookkeeping and Inventory Management (Local
Health Facility Level)

Basic stock taking and bookkeeping procedures will be taught to village health workers and pharmacy clerks from the CVDs operating cost recovery systems in their villages. National level trainers from the MOHP will train the Supervisory/Training teams from each prefecture to teach these courses.

- (11). Training for Laboratory Technicians

As described elsewhere in the Project Paper, the project will support a strengthening of the laboratory analysis capacity at

the prefectoral level. Microscopes will be purchased, and associated training for technicians will be provided by the project.

- (12). Motor Pool training

In another effort to promote decentralization and integration of services, the project has proposed that motor pool operations be strengthened. The vehicles that will be purchased will be managed from a central motor pool, instead of individually, as in the past. Therefore, training will be provided for those responsible for motor pool management.

- (13). CVD Local Health Program Management

Management committees from all 400 facilities in 21 prefectures will be trained over a span of approximately 24 months. IE&C and promotional materials will be provided (e.g., tee-shirts, baseball caps, posters, etc.) for CVD health volunteers receiving no salary and no per diems.

(f). Commodities

- Seven vehicles to the general MOHP motor pool

One of the vehicles will be reserved for the project technical assistance team for the duration of the project. Fuel and maintenance costs of the project vehicle will be covered under the project. 50% of the fuel and maintenance costs will be supplied for the remaining six vehicles. The MOHP will assume 20% of the recurrent costs beginning in year two, increasing 20% each year, with the MOHP assuming 100% of the recurrent cost by year 6.

- 33 new sets of computers, software, printers with support hardware, furniture and supplies and maintenance contract

Nine of the computers and related equipment will be assigned as follows: (1 for the Director General; 2 for the Division of Common Affairs; 4 for the Direction of Planning, and Staff Training; and 2 for Pharmapro).

24 computer systems will be supplied in the third year of the project to the prefectures (21 prefectures plus 3 backup systems), if and when each can meet certain readiness criteria, such as properly functioning manual information systems.

Repair and maintenance contracts will be supplied for five years on all new computers, after which the MOHP will assume the maintenance and supplies costs.

Ten additional computers will be turned over to the MOHP upon completion of the A.I.D.-funded CCCD and HSSCS projects.

- Full costs of printing forms, manuals and the statistical yearbook

These costs will be covered by the project for the first three years. The MOHP will assume this recurrent cost on a gradual basis for the remainder of the project and assume full costs after the end of the project.

- Fuel, Lubricants, and Spare Parts

Fuel coupons, lubricants, and spare parts will be provided for vehicles and motorcycles used for prefectoral level supervision and CVD organization, and health and cost recovery training. The project will provide 100% of the costs the first year of the project. The second year of the project 50% of the costs will be provided. The MOHP will assume 20% of these costs in the third year and will increase their contribution 20% each year for the remainder of the project.

- 21 Photocopiers

Photocopiers, related spare parts, supplies, and repair and maintenance contracts will be provided for each prefecture in addition to the computer equipment mentioned above.

(g). Buy-ins and Sub-contracts

- National Census

The project will provide partial funding for the National Census (whose cost will be shared with other donors). The Census will provide the baseline demographic information needed for assessing health service coverage.

- Demographic and Health Survey

The project will also fund a buy-in to IRD for a follow-on to the 1988 Demographic Health Survey to provide supplementary data on health and fertility, and to measure progress as key indicators for measurement of program impact since the 1988 survey.

- Health Financing and Sustainability Project

The HFS Project will provide a range of short-term technical assistance from macro-level policy development on cost recovery to micro-level assistance in conducting household and market surveys, and costing and pricing studies for products and services.

- MSH/Managing Drug Supply Program

MSH will provide assistance to PharmaPro in the development of a functional pharmaceutical procurement and distribution system. The system will be computerized so as to be responsive to requests from field facilities, with sufficient capacity for

prior estimation of demand to allow the lead time needed for international procurement and importation of essential medicines.

(2). Component Two: Strengthening Integrated and Decentralized Health and Family Planning Service Delivery

The objective of this project component is to promote integration and coordination among the different MOHP programs. The development of the integrated management information system described in component one above will be the foundation of increased program integration. Finally, this component will promote decentralization and delegation of responsibility to the prefectural level by making more inputs available directly to prefectural medical teams.

Program Integration

(a) National Level

The project will help the MOHP implement an integrated model of service delivery at the level of each health facility. The model to be used is based on pilot activities the Ministry has tested with GTZ assistance at the Maternité de Bè in Lomé. Implementing the model will require the following illustrative list of preparatory steps at the national level:

- Codification of health facilities by category, followed by mapping the number and distribution of all facilities (MOHP and private);
- Definition of essential equipment and supplies necessary for program execution at each category of facility;
- Inventory of the location, skills, and experience of all MOHP health workers;
- Development of a plan at the central level to redistribute staff and resources according to demographic and public health requirements;
- Collection, revision and development, where necessary, of standard protocols for disease diagnosis, treatment, education and prevention;
- Development of supervisory checklists to assess the quality of care in relation to the established protocols;
- Survey and research of factors that may encourage or prevent people from seeking health services;
- Survey and research the information, education and communication needs of the programs with the greatest promise of improving public health through behavioral change in the household or community;

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- Identification and establishment in the new Division of Staff Training of a team of selected national trainers capable of training health workers to implement and manage the priority programs of the MOHP.

(b) Prefectoral Level

To implement the integrated health facilities management system, the project will assist the MOHP in setting up an integrated process of program design, staff training, service delivery, and supervision. This will be managed and coordinated by prefectoral medical teams. Prefectoral teams under the leadership of a chief medical officer will use standardized materials, described below, which will be developed under the coordination of the Directorate of Planning and Staff Training. The materials will draw their content from suggestions made by an ad hoc committee of health personnel from all levels of the system, including donors.

The integrated model will require coordinated support services which ensure adequate inputs, and a greater delegation of authority from the Director General at the central level to the Chief Medical Officers in the prefectures, and from the Chief Medical Officers to the Health Facility Managers and eventually to CVDs at the local level.

The 21 Chief Medical Officers, together as a team at the national level, will develop three uniform sets of materials with the assistance of staff of the Directorate of Planning and Staff Training. The types of materials to be developed are:

- (a) a facilities survey for inventorying facilities, physical assets and human resources;
- (b) a Technical and Operations Manual designed as an integrated presentation of policies, procedures, treatment protocols, medical and technical guidance, administrative, accounting, and logistical support forms and systems related to an identified set of related medical interventions. This manual will be used as a basis for the development of training materials for each technical program, and later as reference guides for all health personnel at peripheral facilities. The Supervisory checklist discussed below will be appended to the manual.
- (c) Training Materials and a Supervisory Checklist for initial and continuing staff training, and subsequent supervision to assist in implementing the guidance and directives provided for in the Technical and Operations Manual.

Improvements in Staff technical capacity will be encouraged through the development of three integrated cycles of related technical training concerning specific MOHP service delivery programs. Depending on the stage of development of a given

technical program, diagnostic and treatment protocols as well as drug use manuals will be developed, if not already available. Cascade training modules will be developed for health personnel at the prefectoral level according to the illustrative outline below:

Cycle One will cover the Expanded Program of Immunization (EPI), malaria control, and the control of Acute Respiratory Infections (ARI);

Cycle Two will cover nutrition, growth monitoring, nutrition rehabilitation, and Control of Diarrheal Diseases (CDD); and

Cycle Three will cover safe motherhood, family planning, and AIDS prevention.

Added to these technical training modules will be the training module developed for the revised integrated management information system.

The project will help the prefectoral chief medical officers establish multi-disciplinary teams which integrate the roles of trainer, technical expert, manager, and supervisor in the same individual. The team will consist of five to six members headed by the chief medical officer. It might include the medical assistant, two midwives, one senior hygiene technician, and one social worker. Motorcycles being provided to the MOHP by the ongoing HSSCS project will ensure mobility of these multi-purpose prefectoral teams.

Under the leadership of the Chief Medical Officer, and with assistance of the Division of Staff Training, the prefectoral teams will train workers in all health facilities in the prefecture. All training will be conducted by the prefectoral teams, with donors or the MOHP medical divisions providing background support or co-trainers where required. The Director General has requested that no donor project or MOHP medical division staff from Lomé should be allowed to divert field staff from their routine functions for specialized training without going through the Chief Medical Officers. Such isolated training events conducted by MOHP central level staff from Lomé or expatriates funded by outside donors cannot provide post-training implementation assistance, technical guidance, or routine supervision and will be discouraged under the project.

More detailed guidance and instructions for how the project will provide continuity for existing programs, and expand and improve an integrated program for service delivery is provided in Annex E. Through the integrated model described above, project support will be provided for vaccination, malaria control, diarrheal disease control, nutrition, maternal health, family planning, and AIDS prevention. Support for equipment, materials and supplies, similar to that being provided under present activities will continue in the TCSP. However, cost sharing with the MOHP for these recurrent costs will begin early in the new project.

Finally, where possible, the new project will provide inputs through MOHP administrative channels directly to the prefectoral level in support of service delivery programs.

ILLUSTRATIVE INPUTS

(a) **Technical Assistance:** (in addition to that described under component one above):

- 2 person-months of short term technical assistance to help the national nutrition service strengthen its capacity to plan, manage and coordinate nutrition programs;
- 3 person-months of short term technical assistance to assist the nutrition service in operational research to identify more appropriate approaches for establishing a community level program;
- 4 person-months of short term technical assistance for operational research and studies required for the elaboration of appropriate curricula and training materials for maternal nutrition education;
- 4 person-months for other nutrition research; additional teaching materials to the National Laboratory for up-grading courses for 50 laboratory assistants;
- 36 person-months of technical assistance in specific technical areas and operational research through a PASA with CDC/Atlanta;
- 2 person-months of short term technical assistance to strengthen the SNES management and planning capacities for health education programs.

(b) **Training**

- staff refresher courses on the diagnosis, treatment and prevention of malaria;
- one month of short-term participant training in rehabilitative nutrition and nutrition education (2 MOHP staff members);
- in-country workshops for CVDs in nutrition;
- 2 person-months of participant training for the improvement of IE&C materials;
- 1 person-month of epidemiological training in support of the AIDS control program.

(c) Commodities

- fuel coupons necessary to strengthen prefectoral level supervision and community development activities on a decreasing basis over the life of the project (maintenance and servicing should be carried out at the prefectoral level in the framework of an effective decentralization system);
- microscopes for any of the teams at prefectoral headquarters that need them (estimated to be about 11 of the 21 prefectures);
- Chloroquine on a declining basis;
- vaccines, as required, in collaboration with other donors, also on a declining basis;
- baby scales for health centers that do not currently have them;
- support and equipment for nutritional recuperation units in health centers and dispensaries to allow appropriate surveillance of malnourished children who do not need hospitalization;
- a large-volume, fast-feed photocopier for SNES to duplicate training materials, and a fuel budget so they may supervise health education activities in the field;

Note: For recurrent cost commodities listed above such as vaccines, chloroquine and gas coupons, the project will require that the MOHP establish budget lines early in the project and begin contributing financially to the purchase to ensure long term sustainability.

(3). Component Three: Promoting Public and Private Sector Collaboration in Health and Family Planning

The objective of this component is to develop MOHP capacity to monitor, collaborate with, establish appropriate professional standards for, and provide technical extension services to private practitioners, community health cooperatives, laboratories and pharmaceutical vendors.

As a first step in expanding private sector health and family planning service delivery, the MOHP must: (a) establish a regulatory framework which safeguards professional standards; (b) create linkages with private health care providers in the areas of health training, education, and information; and, (c) encourage the development of and provide necessary training to associations of health professionals in the private sector to

encourage the cooperation between public and private programs in furtherance of the public health agenda.

(i). Regulatory Framework

(a) Categorization of Professional Grades

The project will provide the MOHP assistance to establish standards for the certification of health professionals by category. These standards will permit comparison of the training and experience of different professionals and para-professionals to arrive at a standard determination of professional grade (e.g., Physician Specialist, Physician, Pharmacist, Pharmaceutical Vendor, Medical Assistant, Nurse, Midwife, Traditional Birth Attendant, Traditional Healer, Herbalist, etc.).

(b) Codification of Medical Procedures

Once the skills and experience profiles of various professional grades have been established, the project will provide assistance to the MOHP to establish norms for what specific acts and procedures any given level of health professional or para-professional may perform, supervised or unsupervised.

(c) Standards for Expanding Private Facilities

Once medical professionals are classified, and the professional and technical competence of each category defined, the project will assist the MOHP in setting standards for the provision of services by category of personnel. This will allow doctors, medical assistants, midwives, and other professional or para-professional categories of personnel to establish health facilities and provide services appropriate to their level of training and competence. This will eventually allow increasing numbers of health professionals presently being trained in Togo to enter the private sector, and provide needed services in medically under-served areas.

(d) Private Sector Monitoring Capacity

The MOHP will develop with project assistance a routine capacity to map the activities (service and distribution points) of private sector health and family planning providers. This function will be located in the Division of Private Facilities in the Directorate of Health Care Facilities.

With project assistance, that office will be technically and financially capable of conducting throughout the year, routine visits and spot checks of a broad sample of private sector facilities across the country.

The Offices of Pharmacy and Laboratory Inspections and the Directorate of Pharmacies, Laboratories, and Technical Equipment will also be given assistance in setting and monitoring standards for laboratory tests and the sale of pharmaceuticals. Highly

technical short-term assistance will be provided to improve the capacity to monitor the sale of pharmaceuticals in the market and through informal channels.

(e) Licensing Private Establishments

Once this has been accomplished, the path will be open for the MOHP to authorize broad opportunities for the full range of health professionals to enter into private practices (individual or group). Similarly, the MOHP will be in a position to authorize activities in the distribution and sale of health and family planning products, each within set legal, professional and administrative parameters.

MOHP senior management has agreed that the developed standards and licensing mechanisms should not attempt to set prices in the private sector for projects or services, or otherwise interfere with market mechanisms which do not affect professional considerations. The MOHP will need assistance from the project in responding to organized pressure from some private providers to restrict market access. Government established price schedules are usually justified as indirect means of ensuring an adequate quality of services, but nearly always result in restricting the access and affordability of services to a wealthy urban elite. Quality and professional standards are best achieved by monitoring for their enforcement directly. This will be the approach taken by the project.

(ii). Health Information, Training, and Education

The MOHP and the "Amicale des Médecins Privés" (the professional association to which 90% of Togolese private physicians belong) have both requested that the new project provide assistance in integrating private sector health providers into MOHP professional development and information networks.

(a) Health Information

The Annual Report on National Health Statistics began in 1991 to tabulate the number of physicians, pharmacists, and selected other categories of health workers in private practice in Togo. The MOHP will need assistance in training private practitioners in completing the necessary forms (monthly, quarterly, and annual) to ensure that data on disease incidence and the volume and variety of services and medicines provided are reflected in the annual national health statistics report.

This will require assistance from the MOHP Staff Training and Health Statistics Divisions, coordinated through the Division of Private Facilities, with the help of the project's long- and short-term technical advisors.

(b) Health Training

The Division of Private Facilities will, with project assistance, coordinate with the staff Training Division and the Directorate

of Primary Health Care to include private providers in MOHP training programs. This may involve providing the MOHP with treatment protocols, policy statements and technical bulletins to the private sector as well as inviting them to briefings and training events for new methodologies and technical updates on methodologies already in use.

(c) Health Education

The Division of Private Facilities will also coordinate the channeling of SNES and PNBEF IE&C activities to the private sector. This may be as simple as providing private providers with posters, brochures, and other materials promoting public health awareness and behavioral messages (e.g., for Chloroquine dosages, treatment of diarrhea, nutrition, AIDS prevention, and family planning). At a more sophisticated level, the various types of private channels may be used as a way of segmenting the market for more specific targeting of public health messages.

(iii). Complementary Programming Mechanisms

There are a number of areas where a small investment on the part of the MOHP would yield significant, cost-effective benefits for Togolese public health. For example, private practitioners could be provided vaccines at a subsidized rate to encourage a more complete and effective response to the spread of childhood communicable diseases.

The public health contributions of traditional birth attendants, formerly discouraged from operating in Togo (and as a result driven underground or completely suppressed) will be encouraged through training and establishing guidance on their areas of competence. These personnel will thus be integrated into the public health system instead of remaining marginalized and discouraged from seeking and referring difficult cases to the public health system.

Market vendors may be willing to collaborate with Public Health officials in suppressing the sale of expired, or worthless drugs, if they were to be authorized to sell legally a wider range of drugs, currently reserved in theory to licensed pharmacies. In reality, the market sellers already sell both what is allowed, and what is not. Previous efforts at suppressing unauthorized sales were unsuccessful. Channeling these market forces would result in the current level of household expenditures being more productive and possibly expand the distribution network for products in short supply, such as chloroquine and contraceptives.

Finally, the project will provide technical assistance to associations of private sector health professionals in all fields to increase their administrative and financial capacity. These associations in turn will then be able to train their members in the business aspects of health service delivery, thus further encouraging an increase in private sector facilities.

The project technical advisors will explore with the MOHP and private sector health professionals other areas where collaborative activity would be mutually beneficial. The focus for identifying and sustaining such collaborative efforts should then be institutionalized in the Division of Private Facilities.

ILLUSTRATIVE INPUTS:

Inputs into this component will include:

(a). Long Term Technical Assistance

A Private Sector Health Specialist will be provided for three years to work with the Director of the Directorate of Health Facilities to establish a functioning MOHP capacity to set standards and collaborate with formal and informal private sector practitioners (e.g., doctors, medical assistants, nurses, midwives, pharmacists, pharmaceutical vendors, laboratory technicians, traditional birth attendants, herbalists, and traditional healers).

The Private Sector Health Specialist should be experienced in the development of professional associations and umbrella groups for health professionals, and clinic management (especially financial management and logistics).

(b). Short-term Technical Assistance

The private Sector Specialist will call upon specialized short-term technical assistance to handle issues for the development of Health legal codes, standardized credentialing regimes, categorization of medical procedures approved for specific credential categories, customs regulations for pharmaceutical control, foreign exchange and currency regulations on the importation of supplies and equipment, alternatives to the Togopharma monopoly on drug importation and wholesaling, etc.

EXPECTED OUTPUTS:

(1) Increased public sector capacity to set standards and monitor private sector service delivery and pharmaceutical sales, ensuring acceptable compliance with professional norms and standards.

(2) Establishment of a functioning MOHP technical extension and outreach service to private sector health practitioners and providers.

CONDITIONS AND REQUIREMENTS:

MOHP collaboration with the private sector should encourage the expansion of a broad range of accessible, affordable, and quality health and family planning products and services. Project resources will not be used to aid or facilitate public sector participation in price fixing, or other activities which constrain or limit competition.

(4). Component Four: Expanding and Strengthening Private Sector Health and Family Planning Service Delivery

The objective of this component is to open up opportunities for the expansion of private sector and service delivery product distribution in Togo, especially in presently under-served areas.

(i). Development of Professional Associations

As described above, the project will provide technical and administrative assistance to groups of health practitioners involved with private sector professional associations (e.g., similar to the "Amicale des Médecins", and "Syndicat des Pharmaciens"). All categories of health professionals, para-professionals and traditional practitioners should be eligible to form their own associations, and then receive necessary business and administrative training in support of expanded services.

(ii). Revolving Loan Funds

Once established, consideration will be given by the project staff in collaboration with the MOHP as to the allocation of grants to selected associations for the purpose of establishing revolving loan funds for their members. These loan funds will be established in local lending institutions according to criteria to be developed by project and MOHP staffs. Such loans would be for the purpose of opening or expanding private sector clinics, pharmacies, distribution networks, laboratories, or other legitimate and viable means of ensuring accessible and affordable quality health care in Togo.

At the end of the project, the loan funds will become the sole property of each association if A.I.D. has determined over the course of the project that these funds are being properly managed and used appropriately. The local lending institution will handle the money, and recommend fees and interest rates. Credit to targeted borrowers will be made as accessible as possible, while ensuring the fiscal integrity and sustainability of the fund. Each association will establish lending criteria, payback terms and schedules, and default procedures. Lending criteria will be established in consultation with the MOHP to maximize opportunities for under-employed practitioners, while increasing services to under-served populations, in furtherance of broad public health objectives.

(iii). Clinic and Small Business Management Assistance

Experience in revolving loan funds in health, as well as in other sectors, indicates that a key factor in their success relates to the effectiveness of technical assistance provided to the borrowers in the use of the funds.

The project's Private Sector Health Advisor will draw on the experience of A.I.D.-funded projects in other countries which have provided successful assistance in small business management, especially clinic management and the sale of medicines and contraceptives (e.g., the Sahel Regional Financial Management Project's clinic record, accounting, and inventory system developed in Senegal for doctors in private practice (Experience Inc.); the Enterprise Program's curriculum and manual for small business management developed for Registered Nurse/Midwives in Ghana (John Snow Inc.), and Managing Drug and Contraceptive Sales for non-licensed pharmaceutical vendors (John Snow Inc. has developed materials for Thailand, MSH for Ghana, and the Futures Group has developed marketing materials world-wide).

The Private Sector Health Advisor will help each association develop the capacity to arrange for such technical and start-up assistance for its members. The cost of the assistance could be borne long-term either through membership fees in the association or rolled into the start-up loan and paid back by the borrower. The training and assistance could either be provided directly by the association, if they are in a position to hire full-time staff, or could be procured on the outside market by any number of Togolese firms capable of training practitioners in accounting and small business management. The training and implementation assistance could use or adapt the A.I.D. systems and training materials mentioned above.

ILLUSTRATIVE INPUTS:

- (1) Private Sector Health Advisor (50% of his/her time);
- (2) US\$750,000 for grants to associations of private health practitioners for start-up assistance or service expansion.

EXPECTED OUTPUTS:

(1) Increased number of health and family planning professionals serving in the private sector outside of Lomé (drawn from those currently with the MOHP, or unemployed) according to the following approximate targets:

- (a) 15 additional physicians;
- (b) 30 additional medical assistants;
- (c) 60 additional nurses;
- (d) 120 additional midwives; and,
- (e) 100 additional other health practitioners.

(2) Increased volume, variety, and distribution (geographic and demographic) of health and family planning products and services through the private sector;

(3) Broader range of affordable quality health and family planning products and services especially at the low end of the price range, and in rural areas.

CONDITIONS AND REQUIREMENTS:

To receive loan assistance, the chosen associations must have as their primary purpose enhancing the technical and professional skills of their members, and expanding service delivery across Togo, especially for under-served localities and populations. Technical, administrative, and/or financial assistance should be denied any group which joins together for the purpose of price fixing, or otherwise manipulating the market to restrict competition.

IV. COST ESTIMATES AND FINANCIAL PLAN**A. INTRODUCTION**

The Togo Child Survival and Population project will be implemented over a six-year period. The cost estimates and financial plan are based on an initial obligation of funds in US fiscal year 1991. A detailed cost estimate is included in Section G below.

B. COST SUMMARY

The total cost of the project is estimated at \$21.1 million. A.I.D.'s contribution of \$15.526 million represents approximately 74% of total project cost. The remaining 26% of total cost will be covered by the Government of Togo's contribution to the project.

C. U.S. FINANCED INPUTS

A.I.D.'s assistance will be implemented through an institutional contractor, a local private voluntary organization, buy-ins to existing central projects, procurement of pharmaceuticals and other commodities in the area of contraceptive supply, and direct procurement through A.I.D.'s central commodity procurement process managed by S&T/POP. At least 5% of the institutional budget is allocated for procurement of technical and professional services from local firms. Maximum efforts will also be made by the institutional contractor to use local professionals for short-term technical assistance needs when local expertise is available. The U.S. long and short-term technical assistance will be utilized to assist in project implementation and to transfer skills through on-the-job training.

D. GOVERNMENT OF TOGO FINANCED INPUTS

The GOT contribution will include in-kind and cash contributions that will finance 40 half time MOHP central staff and 50 one quarter time chief medical officers and medical assistants. The GOT contribution also will cover the salaries of 400 health facility managers and 400 midwives at 10% time, totalling approximately \$2.0 million. In addition, the GOT will cover recurrent costs, estimated at about \$1.4 million over the life of the project. These costs will be incurred especially during the last three years of the project. Finally, revenues generated

from the MOHP's pharmaceutical and eventually health delivery cost recovery program estimated at \$1.4 million will be used to replenish essential stocks of medicines and supplies, and cover other MOHP operating expenses.

E. ILLUSTRATIVE BUDGET

The following budget summarizes all project costs:

<u>EXPENSE CATEGORY</u>	<u>A.I.D.</u>	<u>GOT</u>	<u>TOTAL</u>
I. <u>A.I.D. Contribution</u>			
Long-term Technical Assistance	3,040	0	3,040
Short-term Technical Assistance	481	0	481
Buy-in, PASA & contract	2,930	0	2,930
Long-term Participant Training (US)	400	0	400
Short-term Participant Training	400	0	400
In-Country Training (Workshops)	1,065	0	1,065
Research and Studies	500	0	500
Commodities	3,635	0	3,635
Evaluations and Reviews	150	0	150
Audit	150	0	150
Revolving loan Fund (Private Sector)	50	0	750
Contingency and Inflation	2,025	0	2,025
Total AID Project Assistance	15,526	0	15,526

II. Host Country Contribution

Host-Country Salary Contribution	0	2,052	2,052
Host-Country Recurrent Cost	0	1,355	1,355
Host-Country Cost Recovery	0	1,414	1,414
Contingency and Inflation	0	723	723
Total Host-Country	0	5,544	5,544
TOTAL:	15,526	5,544	21,070

F. PROJECTED EXPENDITURES

Table II presents a summary by fiscal year of the projected expenditures for the project. It is derived from the Detailed Cost Estimate presented in Table III below:

TABLE II

TOGO CHILD SURVIVAL AND POPULATION PROJECT
PROJECTION OF EXPENDITURES BY FISCAL YEAR
(US \$)

	A.I.D. ASSISTANCE	GOT CONTRIBUTION	T O T A L
FY 1991	0	27,600	27,600
FY 1992	1,221,108	446,925	1,668,033
FY 1993	4,567,944	571,211	5,139,155
FY 1994	3,718,813	796,082	4,514,895
FY 1995	2,927,325	1,030,712	3,958,037
FY 1996	1,843,881	1,253,563	3,097,444
FY 1997	1,246,792	1,417,797	2,664,589
TOTAL	15,525,863	5,543,890	21,069,753

G. DETAILED COST ESTIMATE

Table III below is the detailed line item budget by fiscal year for the project. This table is the basis of all cost and financial estimates cited throughout this paper.

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IV.	PARTICIPANT TRAINING -LONG-TERM/US	No.								
		yrs								
	1. MPH Health Management	2	0	5,500	22,000	22,000	5,500	0	0	55,000
	2. MS Information System Management	2	0	5,500	22,000	22,000	5,500	0	0	55,000
	3. MS Health Statistics	2	0	5,500	22,000	22,000	5,500	0	0	55,000
	4. MPH Health Admin. & Logistics	2	0	5,500	22,000	22,000	5,500	0	0	55,000
	5. MS Training Management	2	0	5,500	22,000	22,000	5,500	0	0	55,000
	6. MS/MPH Epidemiologist	2	0	5,500	22,000	22,000	5,500	0	0	55,000
	7. MS/MA/MPH Health Finance or Economics	2	0	5,500	22,000	22,000	5,500	0	0	55,000
	8. Misc. Long-Term Training Expenses		0	5,000	5,000	5,000	0	0	0	15,000
	TOTAL PARTICIPANT TRAINING- LONG-TERM/US	14	0	43,500	159,000	159,000	38,500	0	0	400,000
V.	PARTICIPANT TRAINING - SHORT-TERM	No.								
		Mos								
	1. Medical Equipment Repair	6	0	0	21,000	21,000	0	0	0	42,000
	2. PHC Information System Management	4	0	0	14,000	14,000	0	0	0	28,000
	3. Managing Drug Supply for PHC	4	0	0	14,000	14,000	0	0	0	28,000
	4. Financial Management for Health	3	0	0	14,000	7,000	0	0	0	21,000
	5. IEC Materials Development	4	0	0	14,000	14,000	0	0	0	28,000
	6. Child Survival/FP/MCH	6	0	0	14,000	14,000	14,000	0	0	42,000
	7. Integrated PHC Management	1	0	0	7,000	0	0	0	0	7,000
	8. Nutrition and PHC	2	0	0	7,000	7,000	0	0	0	14,000
	9. Techniques in Family Planning	2	0	0	14,000	14,000	14,000	14,000	0	56,000
	10. Cost Recovery Field Visits	8	0	0	14,000	0	0	0	0	14,000
	11. Motor Pool Management	2	0	0	14,000	14,000	14,000	0	0	42,000
	12. Drug Supply Logistics	6	0	0	14,000	14,000	14,000	0	0	42,000
	13. Other Training to be Identified		0	0	9,000	9,000	9,000	9,000	0	36,000
	TOTAL PARTICIPANT TRAINING - SHORT-TERM	52	0	0	170,000	142,000	65,000	23,000	0	460,000
VI.	IN-COUNTRY TRAINING (WORKSHOPS)									
	1. Financial Management for Health #1		0	0	25,000	0	0	0	0	25,000
	2. Financial Management for Health #2		0	0	0	15,000	0	0	0	15,000
	3. National Planning & Budgeting TOT		0	0	4,500	0	0	0	0	4,500
	4. 21 Prefecture Planning & Budgeting		0	0	60,000	0	0	0	0	60,000
	5. National Planning & Budgeting		0	0	4,500	0	0	0	0	4,500
	6. 21 Prefecture Facilities Record Keeping and Management Use		0	0	60,000	0	0	0	0	60,000
	7. National level Facilities Record Keeping & Management Use		0	0	0	4,500	0	0	0	4,500
	8. Computer Training		0	0	0	0	30,000	0	0	30,000
	Introduction to Computers. wp. database management, spreadsheets, and 21 Prefecture level HIS									

	FY1991	FY1992	FY1993	FY1994	FY1995	FY1996	FY1997	TOTAL
9. HIS Systems (follow up to #8)	0	0	0	0	0	30,000	0	30,000
10. National level Medical/Technical TOT for Technical Training Modules	0	0	20,000	0	0	0	0	20,000
11. Cycle 1 Prefecture EPI, Malaria, and ARI	0	0	25,000	0	0	0	0	25,000
12. Cycle 1 Facilities level	0	0	60,000	0	0	0	0	60,000
13. Cycle 2 Prefect Nut, Grwth Mntr, and COO	0	0	25,000	0	0	0	0	25,000
14. Cycle 2 facilities level	0	0	60,000	0	0	0	0	60,000
15. Cycle 3 Prefect FP, MCH, and AIDS	0	0	45,000	45,000	0	0	0	90,000
16. Cycle 3 Facilities level	0	0	27,500	192,500	0	0	0	220,000
17. 21 Supervisory Checklist Mgmt. Cycle 1 (MCs & Trainers)	0	0	9,000	0	0	0	0	9,000
18. Health Post/CVO Stock Management	0	0	4,000	4,000	0	0	0	8,000
19. Laboratory Technicians	0	0	18,000	0	0	0	0	18,000
20. Laboratory Technicians	0	0	9,000	0	0	0	0	9,000
21. Motor Pool Drivers	0	0	4,500	0	0	0	0	4,500
22. CVO Management Training	0	0	45,000	100,000	100,000	38,000	0	283,000
TOTAL IN-COUNTRY TRAINING (WORKSHOPS)	0	0	506,000	361,000	130,000	68,000	0	1,065,000
VII. OPERATIONAL RESEARCH								
Operational Research Studies (5)	0	0	120,000	120,000	120,000	120,000	20,000	500,000
TOTAL OPERATIONAL RESEARCH	0	0	120,000	120,000	120,000	120,000	20,000	500,000
VIII. COMMODITIES								
1. Vehicles (7)	0	0	126,000	0	0	0	0	126,000
2. Vehicle parts, fuel, lubricants	0	0	7,875	10,500	10,500	2,625	0	31,500
3. Fuel coupons for Prefecture Supervision & Community Dev.		2,500	5,000	4,000	3,000	2,000	1,000	17,500
4. Fuel coupons for motorcycles for Supervision and Community Dev.		2,500	5,000	4,000	3,000	2,000	1,000	17,500
5. I.E.C. Materials (Child Surv./FP)	0	0	70,000	70,000	70,000	0	0	210,000
6. Computers & Related Hardware MOPH Computers & Related Hardware MCs	0	0	67,500	67,500	0	0	0	135,000
7. Printing					120,000	240,000	0	360,000
a. Statistical Yearbook (3 yrs)	0	10,000	10,000	10,000	7,500	5,000	2,500	45,000
b. Monthly Report Instruc. Manuals		0	10,000	0	0	0	0	10,000
c. Med./Tech. Training Manuals		0	10,000	0	0	0	0	10,000
d. Monthly Report Forms (3 yrs)	0	0	5,000	5,000	5,000	3,750	2,500	21,250
e. Drug Distribution Forms (3 yrs)	0	0	2,000	2,000	2,000	1,500	1,000	8,500
f. Misc. Other Printing	0	0	4,000	3,000	3,000	2,250	1,500	13,750
8. Computer Software, Supplies, and Spare parts	0	0	28,750	0	86,250	0	0	115,000

	FY1991	FY1992	FY1993	FY1994	FY1995	FY1996	FY1997	TOTAL
9. Computer Furniture & Cabinets	0	0	5,000	0	15,000	0	0	20,000
10. Photocopiers (25)	0	0	12,500	0	37,500	0	0	50,000
11. Photocopier Parts & Supplies, R&M	0	0	15,000	15,000	15,000	11,250	7,500	63,750
12. Training Materials and Equipment	0	0	20,000	0	0	0	0	20,000
13. Medicines				7,500	5,000	2,500	1,000	36,000
a. Vaccines (Measles)	0	10,000	10,000	30,000	20,000	10,000	4,000	144,000
b. Iron Folate	0	40,000	40,000	30,000	20,000	10,000	4,000	144,000
c. Chloroquine	0	450,000	450,000	337,500	225,000	112,500	45,000	1,620,000
14. Contraceptives	0							
15. Medical/Laboratory Equipment								
a. Microscopes (10)	0	0	20,000	0	0	0	0	20,000
b. Photometers (26)	0	0	40,000	0	0	0	0	40,000
16. Documentation Center Equipment	0	0	2,000	0	0	0	0	2,000
17. Toolkits for Med/Tech Repair	0	0	2,000	0	0	0	0	2,000
18. Special Equipment for PNB	0	0	250,000	0	0	0	0	250,000
19. Special Equipment for Nutrition Ser.	0	0	20,000	0	0	0	0	20,000
20. Re-equipment of Refrig. for EPI	0	0	50,000	0	0	0	0	50,000
21. Furniture and Material for Nat. Lab.			2,000	0	0	0	0	2,000
ATBEF								
22. Equipment for Second Clinic	0	0	10,000	0	0	0	0	10,000
23. 4 Regular IFC Units			20,000	0	0	0	0	20,000
TOTAL COMMODITIES	0	555,000	1,359,625	596,000	647,750	405,375	71,000	3,634,750
IX. Total Evaluations and Reviews	0	12,500	12,500	50,000	12,500	12,500	50,000	150,000
X. Total Audit	0	0	50,000	0	50,000	0	50,000	150,000
XI. Total Revolving Loan Fund	0	0	0	187,500	187,500	187,500	187,500	750,000
XII. A.I.D. PROJECT ASSISTANCE	0	1,061,833	3,972,125	3,233,750	2,545,500	1,603,375	1,084,167	13,500,750
XIII. A.I.D Contingency and Inflation (15%)	0	159,275	595,819	485,063	381,825	240,506	162,625	2,925,113
XIV. TOTAL AID PROJECT ASSISTANCE		1,221,108	4,567,944	3,718,813	2,927,325	1,843,881	1,246,792	15,525,863
XV. HOST-COUNTRY CONTRIBUTION								
1. SALARIES								
a. 40 Halftime MOPH Central Staff & 50 25%-time Medecins-Chefs & ATH's	0	150,000	150,000	150,000	150,000	150,000	150,000	900,000
b. 400 Health Facility Managers & 400 Midwives at 10% Time		192,000	192,000	192,000	192,000	192,000	192,000	1,152,000

	FY1991	FY1992	FY1993	FY1994	FY1995	FY1996	FY1997	TOTAL
TOTAL HOST-COUNTRY SALARY CONTRIBUTION	0	342,000	342,000	342,000	342,000	342,000	342,000	2,052,000
2. NON-SALARY RECURRENT COSTS								
a. Fuel coupons for Prefecture Supervision & Community Dev.	0	2,500	0	1,000	2,000	3,000	4,000	12,500
b. Fuel coupons for motorcycles Supervision and Community Dev.	0	2,500	0	1,000	2,000	3,000	4,000	12,500
c. Statistical Yearbook (3 yrs)					2,500	5,000	7,500	15,000
d. Monthly Report Forms (3 yrs)						1,250	2,500	3,750
e. Drug Distribution Forms (3 yrs)						500	1,000	1,500
f. Misc. Other Printing						750	1,500	2,250
g. Photocopyer Supplies, R&M						3,750	7,500	11,250
h. Medicines								
1. Vaccines (Measles)	0	0	0	2,500	5,000	7,500	9,000	24,000
2. Iron Folate	0	0	0	10,000	20,000	30,000	36,000	96,000
3. Chloroquine	0	0	0	10,000	20,000	30,000	36,000	96,000
i. Contraceptives	0	0	0	112,500	225,500	337,500	405,000	1,080,500
TOTAL GOT NON-SALARY RECURRENT COST CONTRIBUTION	0	5,000	0	137,000	277,000	422,250	514,000	1,355,250
3. COST RECOVERY								
a. Govt facility								
1. Health Cards	14,000	21,630	29,705	38,245	47,271	56,804	66,867	274,523
2. Other Commodities/Services	0	0	80,000	120,000	160,000	184,000	200,000	744,000
b. Private facility								
1. Services	0	0	15,000	15,000	20,000	25,000	35,000	110,000
2. Contraceptives	10,000	20,000	30,000	40,000	50,000	60,000	75,000	285,000
TOTAL HOST COUNTRY COST RECOVERY CONTRIBUTION	24,000	41,630	154,705	213,245	277,271	325,804	376,867	1,413,523
XVI. GOT PROJECT CONTRIBUTION	24,000	388,630	496,705	692,245	896,271	1,090,054	1,232,867	4,820,773
XVII. GOT Contingency and Inflation (15%)	3,600	58,295	74,506	103,837	134,441	163,508	184,930	723,116
XVIII. TOTAL GOT PROJECT CONTRIBUTION	27,600	446,925	571,211	796,082	1,030,712	1,253,563	1,417,797	5,543,889
XIX. TOTAL PROJECT	27,600	1,668,033	5,139,155	4,514,895	3,958,037	3,097,444	2,664,589	21,069,752

H. FINANCIAL MANAGEMENT AND AUDITS

Most project assistance funds will be committed through A.I.D. direct contracts and buy-ins with U.S. firms which are required by A.I.D. to be audited annually. The institutional contractors will be responsible for contracting locally with independent auditors for non federal review of project activities, especially the revolving fund to the yet to be identified private health association. Funds for such reviews are included in the budget.

I. OBLIGATION SCHEDULE

Table IV shows project obligation by fiscal year. Current plans are to obligate \$3,762 million in FY 1991; \$2,500 million in FY 1992; \$4,250 million in FY 1993; \$2,000 million in FY 1994; \$2,000 in FY 1995; and \$1,014 million in FY 1996 for a total of \$15,526 million.

The OAR will sign a grant agreement with the GOT for this project. The ECPR and PP guidance cable delegates authority to authorize the project from the Assistant Administrator for the African Bureau to the A.I.D Representative in Togo, subject to REDSO/WCA Director's concurrence. The A.I.D. Representative will sign the project paper authorizing the proposed activities and approving the initial obligation. Subsequent authorizations and obligations will be executed by the A.I.D Representative in Togo following review and concurrence by the Regional Legal Advisor and other REDSO staff according to Delegation of Authority 551. OAR/Togo will issue project implementation letters periodically to elaborate on terms and conditions of the agreement and implementation procedures.

TABLE IV
OBLIGATION SCHEDULE BY FISCAL YEAR (FY)
(U.S. \$000)

	<u>FY</u> <u>1992</u>	<u>FY</u> <u>1992</u>	<u>FY</u> <u>1993</u>	<u>FY</u> <u>1994</u>	<u>FY</u> <u>1995</u>	<u>FY</u> <u>1996</u>	<u>TOTAL</u>
Obligation	3,762	2,500	4,250	2,000	2,000	1,014	15,526

V. PROJECT MANAGEMENT AND IMPLEMENTATION RESPONSIBILITIES

A. PROJECT MANAGEMENT AND COORDINATION

Management responsibilities for the TCSP project rest with the GOT, ATBEF, and OAR/Togo. The MOHP will be the central point for coordinating all project activities, including policy coordination with ATBEF.

The project's technical assistance services will be provided through an institutional contractor which will be jointly selected by OAR/Togo and the MOHP during the first year of project implementation.

Government of Togo

The implementing agency for the Government of Togo will be the Ministry of Health and Population. The MOHP will assign qualified counterparts for the contract long-term technical advisors outlined in the section on the contracting firm below. The following counterparts will be responsible for implementation of project activities:

The Director General (DG) - counterpart for the Chief of Party (COP); (Note: The Administrative Assistant will work with both the COP and the DG);

The Director of the Division of Training - counterpart for the Health Trainer;

The Director of the Division of Statistics - counterpart for the Management Information Specialist;

The Director of the Directorate of Common Affairs - counterpart for the Facilities Management/Logistics Specialist (who will also work with the Director of PharmaPro);

The Director of the Division of Finance - counterpart for the Financial Management Advisor;

The Director of the Directorate of Health Care Facilities - counterpart for the Private Sector Health Specialist;

The MOHP will also assign sufficient staff at the central level statistics office and at the prefectoral level to ensure that the revised health information system is developed according to the project's final work plan, and that the new system will be managed to produce the required reports, as discussed under Component One above.

The Director General of the MOHP will be the GOT authorized representative to the Project. The Contractor's chief of party (COP) will be a technical advisor to the Director General. As such, it is extremely important that the COP be a senior level health administrator and planner, who can operate comfortably within the Ministry at that level.

However, since the Director General will have many other responsibilities, the COP will spend the bulk (e.g., 75%) of his/her time working with the Director of the Directorate of Planning and Staff Training. The responsibility for day to day management of the Project will be at this level.

The following committees will be formed to handle appropriate technical and management responsibilities under the project:

Policy Task Force

The MOHP will create a policy making and strategy definition task force, chaired by the Director General, with representatives from USAID, the five MOHP Directorates, the Ministries of Plan and Finance, and the private sector. This task force will be a

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policy making and strategy definition body, providing overall guidance and direction to the project. This task force will not be responsible for day to day project management. This responsibility will be located in the Direction of Planning and Staff Training, as discussed above.

Management Information System Commission

The Ministry will designate a Management Information System Working Commission broadly representative of data collectors and users from all levels of the MOHP, with representation from the Ministries of Finance and Plan and private sector health providers. The Director of the Directorate of Planning and Staff Training will serve as secretary to the Commission, and ensure that the revised Health information system will be completed according to the agreed upon time schedule.

Cost Recovery Working Committee

The MOHP will also designate a Cost Recovery Working Committee with representatives from the Division of Finance, the Community Affairs Service, the Chief Medical Officers, CVDs, and PharmaPro. This committee will reconcile the varying pilot cost recovery systems and lessons learned to establish and advise on the implementation of a uniform MOHP system for cost recovery.

Public/Private Sector Advisory Committee

Finally, the MOHP will designate a Public and Private Sector Health Advisory Committee with representation from the Directorates of Planning and Staff Training, Health Facilities, Pharmacies and Laboratories, and a broad range of private sector health providers. This committee will include doctors, pharmacists, laboratory analysts, medical assistants, nurses, midwives, and traditional birth attendants and healers. The committee will provide the DG with guidance on issues of private sector health care, such as regulation, information exchange, collaborative programming and service expansion. This committee will assist the MOHP and OAR in defining the categories of personnel that will benefit, and the criteria that will be used in allocating resources from the loan fund to be set up by the project to encourage private sector expansion of health services.

Office of the A.I.D. Representative

OAR, with the concurrence of the MOHP, will be responsible for contracting with an institutional firm to provide long- and short-term technical assistance, and for the procurement of some commodities. The responsibilities of the contracting firm are described in the next section.

OAR involvement in project management will consist of participating in the policy level task force described above, reviewing and approving annual project work plans and budgets, and dealing with overall contract management, including the approval of long and short term technical assistance consultants.

OAR's project management staff will consist of one US direct hire Health and Population Officer, one PSC physician presently on OAR

staff and a Technical Advisor in AIDS and Child Survival (TAACS) who will act as the main liaison between OAR and the project.

The responsibilities of the OAR's project management staff will include:

focusing on the implementing agencies' compliance with agreed upon conditions precedent and covenants, policies, procedures, A.I.D. regulations as stated in the Grant Agreement and confirmed through work plans and financial and progress reports;

ascertaining how the overall implementation process, such as contractors' performance, financial management and public - private sector participation and coordination, is functioning;

monitoring the project and preparing reports for OAR and A.I.D., as required;

preparing and reviewing with the GOT any changes or revisions in the Grant Agreement;

coordinating and carrying out the necessary reviews and evaluations to ensure that the project provisions are properly implemented; and

coordinating and reviewing proposals for the allocation of local currency.

Over the last three years, OAR's strategy has been to focus the Mission's portfolio on two major sectors, rural development and child survival. A major reason for this focus was to reduce the management burden on OAR staff.

By the end of 1992, the first year of TCSP implementation, the Mission's project portfolio will have been reduced to two projects, reflecting the integration of the current three child survival-related projects into one. OAR direct hire staff will soon be increased by one. This additional person will focus on evaluation and monitoring within the entire portfolio, and will thus assist with management of the TCSP Project. Finally, the OAR program officer will be involved with project management and oversight as appropriate.

Contracting Firm

During the first two quarters of FY 1992 OAR, in collaboration with the MOHP, will define the terms of reference and develop a Request for Proposals (RFP) document for the selection of a contracting firm which will be responsible for providing the long- and short-term technical assistance personnel as shown in the Detailed Cost Estimate for the project. The RFP will be published in the Commerce Business Daily. Once proposals are received, a technical review committee will be constituted with representatives from OAR, the MOHP, and REDSO/WCA. The proposals will be reviewed and rank ordered to guide final selection of the firm that will implement the project.

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Seven positions that make up the technical assistance team have been identified. These positions will be filled under long term contract, with two of them stipulated as local hires.

- Chief of Party/Health Manager (60 mos);
- Project Administrator (local hire) (60 mos);
- Management Information Programmer TA (36 mos);
- Facilities Management/Logistics Specialist (36 mos);
- Financial Management TA (local hire) (36 mos);
- Health Trainer (24 mos.);
- Private Sector Health Specialist (36 mos).

In addition, a total of 37 person-months of short-term technical assistance will be provided by the contractor according to needs to be defined during implementation.

Finally, the contractor will provide initial procurement support and local currency financing to undertake initial project activities in-country. Procurement responsibilities and in-country costs to be financed by the contractor will be defined in detail for the first two years of the project, and will be part of the RFP to be issued.

As can be seen from the list of long-term technical assistance personnel, only the chief of party and the project administrator are expected to stay for the full five year implementation period of the project. The other advisors will be in-country for periods ranging from 2 to 3 years. One of their major responsibilities during this period is to set up MOHP financial, procurement and administrative systems which will improve MOHP institutional capacity to manage and administer its own programs.

Once these systems are in place and the long term advisors leave, project financing will be provided directly to the MOHP on the basis of annual work plans and advances to be supplied by REDSO/WCA/WAAC. Prior to the departure of the advisors, OAR, the MOHP and the contractor will develop the first annual work plan to be implemented directly by the MOHP. At that time, OAR will submit a Project Implementation Letter (PIL) to realign the overall project budget and add an A.I.D. direct local cost budget line. The money to finance this new line will be taken from Sections VI, VII, and VIII of the project's Detailed Cost Estimate.

ATBEF

ATBEF will develop its service delivery and social marketing capacity through the technical assistance and commodity procurement provided under this project. Assistance will be provided through a combination of local contracts for social marketing and product distribution, and short-term technical assistance, generally provided through buy-ins to several A.I.D.-centrally funded projects.

Private Sector Associations

Once Project Components Three and Four begin implementation, a number of private sector associations will be identified to collaborate with the Project. These associations will assist in

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establishing criteria for the management and financial control of the revolving loan fund described in Component Four.

B. IMPLEMENTATION CALENDAR

A Project Grant Agreement obligating the first tranche of A.I.D. funds for the project is scheduled to be signed by the end of September 1991. A detailed Implementation Schedule is included as Annex II, attached to this Project Paper. The sequence of activities as presented in this Annex are not tied to specific dates, but represent an illustrative time-line showing the sequence of activities necessary for project implementation. True project implementation, defined by the arrival in-country of the technical assistance team, will probably not begin until late in FY 1992. USAID support to the sector will be assured in the meantime by the recent extension of its three existing child survival and population projects until December 1992.

The sequence of most activities should remain internally consistent, if the project start-up is delayed. However, the events most likely to be affected by delays in start up, and therefore requiring adjustments to the implementation schedule, are:

- (a) the long- and short-term participant training in the U.S., which must respect the established calendars of the academic and training institutions involved; and,
- (b) the activities preparatory to the MOHP planning and budgeting must be conducted sufficiently in advance of the end of one calendar year to coincide with the GOT's overall deadlines for government planning and budgeting.

C. DONOR COORDINATION

Over the past five years donor support to the health and population sector in Togo has increased considerably, both in terms of total support as well as proportional support to the system of primary health care. In effect, much of the Ministry's primary health care system is now financed by outside donors. The strategy proposed in the present paper for project implementation and administration was designed to take these facts into account. The project will assist the Ministry in managing its internal and external resources in a more efficient way. This includes coordinating donor inputs in a more rational manner.

In the constraints section of this paper the present situation in the MOHP of vertical, fragmented programs is outlined. It is pointed out that this situation is often exacerbated by the donors themselves as they come with their own development agendas to implement. OAR has seen this fragmentation and duplication of effort within its own portfolio of support to the Ministry.

These observations have led to the proposal to combine all USAID support under one integrated project, with a major objective of helping set in place a functioning system of planning and coordination in the Ministry. It is expected that the new Directorate of Planning will play an important role in ensuring better donor coordination as well as coordination between existing programs in the Ministry. Under the direction of the Director General of the Ministry, this Directorate will facilitate the implementation of a planning and budgeting process which will require all donors to program their resources in support of Ministry priority programs and strategies.

Presently donors in Togo loosely coordinate their activities through irregular communications and invitations to their respective activities. There are already some areas where coordination of specific programs has occurred rather smoothly -- such as the EPI and malaria programs where CCCD, UNICEF, and WHO appear to work well together. This type of coordination will continue under the present project, but will be augmented by a strengthened planning capacity within the Ministry itself.

In addition, a yearly planning conference for major MOHP divisions and donor representatives has been held the last two years to plan activities for the following calendar year. This is the first year that the planning and coordination meeting is being held at the correct time in the planning cycle to have real planning impact. This planning process will continue to be further refined in the proposed project. It is expected that this process will significantly improve coordination of donor-supported programs, and will also give the Ministry a chance to see that its own priorities are addressed by the donors.

This process is sometimes complicated by the fact that all donors have their respective internal planning and budgeting cycles which are not synchronized, and do not necessarily correspond with the Government's own. However, the yearly meeting at the appropriate time can help the donors themselves to better plan and program their bilateral assistance to the GOT.

In addition to the yearly formal session, USAID and UNICEF have begun meeting bimonthly on an informal basis to share ideas and to coordinate activities. Recently this informal meeting was expanded to include GTZ, and in the future with the implementation of the present project, other donors will be included. This activity will develop into a more formal process with the implementation of the World Bank's sectoral adjustment loan. The present project supports the management and administrative improvements called for under this adjustment program, and as such will confirm USAID's important role in the sector.

Finally, a very important area of coordination is presently underway at the request of UNDP. This concerns the payment of per-diems to GOT personnel working in support of donor-assisted projects. Presently, the Government has no official per diem policy which the donors can discuss, negotiate, modify, or support. The result is that each donor has its own unofficial or official per diem policy, which has not been discussed or

reconciled with the other donors. This has led to a situation where different Ministry programs play the different donors off against each other in an attempt to get more per diem for project related activities.

USAID, which has developed its own official per diem policy following A.I.D./W guidance, will play an important role in this donor coordination process on the issue of per-diems. Once this issue is resolved, it will also be much easier to ensure effective donor coordination across the board.

D. PROCUREMENT PLAN

The project is financed 100% from the Development Fund for Africa (DFA) Appropriation Account. All procurement will be conducted following the procurement guidelines for activities financed under the DFA. The project will utilize to the extent practicable goods and services of U.S. origin and from U.S. sources.

Long-term and short-term technical assistance, except for locally recruited consultants, will be provided by a U.S. contractor. All vehicles will be procured from code 935 sources due to the local availability of parts and maintenance shops. Long-term participant training will be undertaken in the U.S., at local and regional training institutions, or in other developing countries. Computer equipment and software may be purchased from other free world country sources (code 935) depending on the availability of software in french and local maintenance and repair capacity for equipment.

OAR/Togo with the assistance of A.I.D/Washington's office of transportation (SER/OP/Trans) will make every effort to ensure that commodities procured directly by A.I.D or through A.I.D. contractors will be shipped on U.S. flag carriers in compliance with the U.S. Cargo preference Act. The OAR/Togo project manager will maintain records of all project procurement by A.I.D. Geographical code and will report this information annually to A.I.D./W. OAR/Togo is maximizing to the extent possible U.S. procurement with the development of the foregoing plan in accordance with Africa Bureau Guidelines.

Title to Property

Title of vehicles and commodities purchased with A.I.D. funds under the grant shall be vested in the project during implementation. Direct and indirect costs associated with their implementation will be covered by A.I.D. and GOT funds under the project. Upon termination of project activities, final disposition of vehicles and commodities will be vested in project implementation agencies, public and private.

1. Procurement of Technical Services

A.I.D. will procure most of the long-term and some of the short-term technical services through direct contracting. The competitively selected institutional contractor will be supported by other technical assistance procured through Personal Services

Contracts (PSCs) such as for the locally hired administrative officer and local technical experts for research and studies. OAR/Togo, assisted by the contracting officer at REDSO/WCA, will solicit proposals by advertising in the U.S. Commerce Business Daily. OAR includes the possibility of a PASA with CDC to cover a long-term resident advisor. A joint A.I.D./GOT selection committee will select an appropriate contractor, and REDSO/WCA/OP will execute a contract with the selected firm. The joint committee will evaluate the technical merits of all proposals and recommend a short list of firms to the regional contracting officer for contract negotiation and execution.

2. Buy-ins and PASAS

Technical assistance for short-term services will be obtained through buy-ins to centrally-funded contracts or cooperative agreements in A.I.D./Washington's offices of Health Nutrition and Population. Programs already identified for consideration to enter into these arrangements are : IRD for the 1993 DHS survey, SEATS for family planning service delivery support, INTRAH for family planning training services, SOMARC for social marketing of contraceptives, HFS for cost recovery and health financing support, MSH for managing drug supply, and Mother Care and Population Communications Services for IEC. Short-term technical assistance also will be obtained through CDC PASA arrangements for medical technical advisors. An illustrative list of these technical assistance needs are listed below:

BUY-INS and PASAS

1. CDC/Medical-Technical Advisors (PASA)
2. IRD (DHS study)
3. SEATS (FP & PS Clinics)
4. INTRAH (FP Training)
5. SOMARC (Social Marketing)
6. HFS (Cost Recovery)
7. MSH (Managing Drug Supply)
8. Mother Care (IEC)
9. Population Communications Service (IEC)

E. PARTICIPANT TRAINING PLAN

The project will finance a number of participants for long and short-term training, in Togo, other third world countries and in the US. Most training will, however, be held in-country where they will be conducted in the form of workshops and seminars.

The exact locations of seminars, workshops and other in-service country training will be identified by the institutional contractor who will use the proposed training plan to develop a detailed training plan as part of the annual work plan for review and approval by USAID and the GOT.

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F. METHODS OF IMPLEMENTATION AND FINANCING

Table V presents a summary of the methods of financing for the planned project activities. The table describes the contracting method, type of procurement, and financing method. An estimated value for each method of implementation and financing is also provided.

The methods of financing to be used are A.I.D. direct payments and Federal Reserve Letters of Credit. Procurement will be by direct contract or, in the case of contraceptives, through A.I.D.'s Commodities and Program Support Division (CPSD).

TABLE V
METHODS OF IMPLEMENTATION AND FINANCING

<u>METHOD OF IMPLEMENTATION</u>	<u>METHOD OF FINANCING</u>	<u>(U.S. \$000)</u>
Institutional Contract* (Technical Assistance, Training, Commodities)	Direct Payment	6,060
Buy-ins	Direct Payment	2,930
Training	Direct Payment	1,341
NGO (Revolving Fund)	Letter of Credit	750
A.I.D. Procurement (Contraceptives and Contractor Support)	Direct Payment	1,620
Direct Contract (Financial Assessments Evaluations and audits)	Direct Payment	300
Research & Studies	Direct Payment	500

* It is possible that financing for long-term PASA with CDC may be taken out of this funding.

G. GRAY AMENDMENT CONSIDERATIONS

OAR/Togo and REDSO/WCA will examine the possibility of utilizing Gray Amendment firms to provide technical assistance, training, procurement, and evaluation services. OAR/Togo and REDSO/WCA will seek the widest possible competition among qualifying firms. To increase the probability of utilizing Gray Amendment entities, OAR/Togo and REDSO/WCA will mail Request for Proposals (RFPs) directly to those firms identified by the Africa Bureau as possessing the required expertise. In the event that two or more firms appear equally qualified and one of these is a Gray Amendment entity, preference will be given to the latter.

If after full and open competition, a non-Gray Amendment firm is selected, the chosen firm will be required to sub-contract at least ten percent of the total contract price to Gray Amendment firms. Eventual sub-contracting activities will be closely monitored by OAR/Togo and REDSO/WCA.

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VI. SUMMARY OF PROJECT ANALYSES

A. Summary of Institutional Analysis

Introduction

This project will be implemented by the Ministry of Health and Population (MOHP), and a number of private sector organizations and associations. The institutional analysis outlines the major actors in the sector and describes how they relate to each other. It describes a situation where the MOHP is the largest provider of health care services, both curative and preventive. The MOHP manages most of the curative care institutions in Togo, as well as providing nearly all preventive services.

The findings during the design phase of the project reveals, however, that the MOHP itself now recognizes the need to share responsibility more equally with the private sector over the long term. This is particularly relevant for curative care. The last two components of the project were developed to encourage the MOHP to translate this willingness into reality through the installation of more private health care providers in under-served areas of Togo.

A number of issues related to institutional questions were examined in the analysis. The major issues discussed in the analysis are outlined below.

Decentralization

The analysis describes the MOHP as a highly centralized institution, with both major and minor decisions made in Lomé. Chief medical officers in the prefectures have little authority or discretionary power over programs, personnel, or budgets. At the lowest service delivery level, health personnel are subject to constantly changing demands of different vertically organized programs, and inadequate supplies and equipment. Even at the central level, decisions are often not made because of the press of demands on a few key decision-makers.

Under the re-organization plan of the MOHP developed with the World Bank, decentralization is emphasized as a major objective. The MOHP is aware that decision makers in Lomé are too distant from the day to day operations of health service delivery to plan and budget appropriately for each health facility. The project has picked up on this theme and proposes to support decentralization by focussing resources at the prefectural level, as opposed to the central level focus which has predominated to date. Finally, the project will install a revised, comprehensive information system to provide sufficient data to senior decision makers so they can set and communicate clear goals, strategies and budget constraints, the first requirements for effective decentralization. This system will also provide sufficient feedback to supervisors to allow them to know whether the performance of their staff meets acceptable criteria.

Integration

Presently the MOHP is fragmented into a series of relatively isolated vertical programs, such as EPI, malaria control, and maternal and child health. These programs rarely coordinate their activities. Training activities are often duplicative and poorly coordinated. Different programs often place competing demands on health providers' time at the lower levels of the system. Separate information and reporting forms exist for each program.

To date, external donor (particularly bi-lateral) funding has been programmed in the traditional way through projects. These projects, including those presently funded by USAID, are almost all focussed on specific technical interventions, and are implemented through technical divisions of the MOHP. While this funding has been used appropriately in most cases, the availability of external resources in separate technical divisions at the central level has led to a fragmentation of efforts and various competing interests, with no overall view toward strengthening MOHP systems.

The present project has been designed to overcome this problem by integrating itself more completely into the MOHP administrative structure, and not standing alone as a project. To do this, certain institutional capacities (especially MIS, financial management, and procurement) will need to be further developed during the project, so that later in the project period, non-project assistance will be programmed.

Reorganization

The issue of greatest importance for this project from the institutional analysis is the question of reorganization of the Ministry of Health and Population (MOHP). Both the current and new organization charts are presented in the annex. The reorganization takes on even greater significance when considered in the light of the present political changes now occurring in Togo. When the entire Government changes as expected in September, there will be opportunities, which otherwise would not be, to change systems. In addition, some personnel will also inevitably change, thus opening up areas that may have been blocked for years.

As shown in the analysis, a major constraint to improving efficiency in the MOHP is the present lack of an official planning function in the Ministry. The present planning unit is attached artificially to the Ministry structure as a separate project, and is not effectively integrated or utilized as a result. Under the reorganization, a Directorate of Planning and Staff Training will be created, which will become the main focus of activity under the new project.

Training program coordination

The training provided under uncoordinated donor projects has too often lacked appropriate criteria for trainee selection, and inadequate opportunity for implementation of what was learned. The project will focus on training which is closely related to

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job performance and final work output. Finally, the project will develop procedures which de-emphasize the per-diem aspect of training, and emphasize the professional satisfaction of improved work performance and eventual service delivery improvement to beneficiaries.

Conclusion

After working in this sector for over ten years, USAID has developed a good understanding of the constraints hindering more efficient operations. The particular institutional lessons learned through past projects and experience of other donors have led to the proposed project strategy. With the MOHP reorganization new opportunities for institutional strengthening will be created, and the project will be there to take advantage of them.

B. SUMMARY OF TECHNICAL ANALYSIS

Technical Interventions

In terms of public health technologies to be supported by the project, the choice of program interventions (vaccination, diarrheal disease control, nutrition, malaria control, maternal health and AIDS control) is supported by the technical analysis. Both vaccination and malaria have proven to be successful USAID sponsored activities in the present portfolio, and important gains have already been made.

(i) Expanded Program of Immunization (EPI)

The major issue identified in both the technical and financial analyses for the EPI program is that of sustainability. On the technical side, the issue is one of concentration. Over the past five years, the EPI program has received enormous amounts of attention from donors as well as the MOHP itself. This has led to startling successes, but at the price of less attention given to other priority programs.

The technical analysis confirms that the project should continue to support this important program, but suggests that increasing attention be given to the issues of sustainability and institutionalization. Increasing integration of the program into overall Ministry systems will be encouraged. Support for vaccines and equipment is proposed, but conditions will be imposed requiring the MOHP to begin immediately to establish its own budget lines for these items and over the course of the project to assume increasing responsibility for their procurement.

(ii) Malaria

The technical analysis shows that while the malaria program has developed into a well managed activity, it is also over centralized and needs better integration into overall Ministry systems. Due to increasing parasite drug resistance, the control program has not significantly diminished morbidity, but has been very successful in controlling mortality. Chloroquine use for

treatment of suspected malaria by health personnel clearly has been improved over the last few years, due to policy and training initiatives taken by the MOHP.

Because of the importance of malaria in the disease profile of Togo (14% of deaths caused by malaria in 1989; 37% of total consultations due to malaria in 1990), the analysis suggests that USAID should continue to support the program. Like the EPI program, USAID support for the purchase of chloroquine in the project will be on a declining basis over the life of the project. The analysis points to the need to integrate the chloroquine distribution and information collection needs of the malaria program into overall MOHP systems, and finally a need to complement the treatment strategy with other appropriate control methods.

Due to rapidly changing conditions, the technology for malaria control activities, particularly in Africa, is also evolving. To keep up with this technology development, the analysis proposes that the project retain some form of association with the Centers for Disease Control (CDC). The details of this association will be further developed in initial implementation stages.

(iii) Control of Diarrheal Diseases (CDD)

The analysis points to the importance of diarrheal disease in the morbidity and mortality profile of Togo (fourth cause of total consultations in 1989, and fifth cause of deaths in the same year), and suggests that this program receive increasing attention in the present project. It was noted that the CDD program has received both USAID and other donor attention over recent years, as well as emphasis by the MOHP, but in spite of this attention, has not proven as successful as the EPI and malaria programs.

Like the EPI program, the technology for providing oral rehydration therapy to prevent deaths due to diarrhea has been well developed and is accepted as effective all over the world. Unlike the EPI program, which relies on a sophisticated technology of vaccine development and only a limited number of contacts with the system to succeed, the CDD program relies on important behavior changes on the part of mothers when their children become sick with diarrhea. Achieving these changes has proven difficult in Togo, as in other developing countries.

Lack of policy definition and strategy direction for the program, difficulty of making ORS packets easily available to families, weaknesses in the IEC program, and apparent lack of support for the program by some providers, were all identified as constraints. Existing strategies for addressing these problems exist and will be employed by the project.

(iv) Nutrition

The analysis reveals that malnutrition in Togo is a major public health problem which has received little effective attention to date. According to the 1988 DHS, 31% of children suffer from chronic malnutrition and 5.3% from acute malnutrition.

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Malnutrition was reported as the third leading cause of death in 1989.

The existing technology of appropriate growth monitoring, coupled with nutritional rehabilitation of children thus identified as malnourished has been proven effective in programs where the necessary technical assistance resources and training capacity exists. The analysis shows that appropriate USAID interventions in this field could significantly improve the present program.

It further notes that USAID is already supporting a growth monitoring and nutrition program with Title II foodstuffs, which operates through the Ministry of Social Affairs and Women's Condition (with technical and administrative support from Catholic Relief Services). It suggests that as USAID increases its support to the MOHP program, additional ways of cooperation and coordination be developed with the existing Title II program.

(v) Maternal Health

The analysis points out the importance of this program in the light of connections between existing maternal and child health programs, including family planning, and the health of pregnant women and mothers. Technically, the connection between appropriate pre- and post-natal care for mothers, and the health of these same mothers' children has been shown elsewhere throughout the developing world. The technical analysis suggests that a major strategy in the project should be to encourage increased integration of MOHP preventive programs, including maternal health (or the safe motherhood initiative, as the program is termed in Togo).

Data on the impact of this program to date are widely varying, and thus difficult to interpret. Without using the precise numbers, it seems that a large percentage of pregnant women report receiving some pre-natal care (70-85%), but significantly lower numbers (50-65%) report giving birth under any kind of controlled medical supervision (this is particularly true outside of Lomé, where one study showed only 7% of women giving birth under medically controlled conditions). Maternal mortality (estimated at 700/100,000) is relatively high, but these statistics are somewhat unreliable. The analysis suggests that the project should strengthen the maternal health program in the context of program integration, particularly with regard to the EPI and family planning programs.

(vi) Family Planning

The technical analysis points out the importance of improving the family planning program in Togo, both from an economic and maternal and child health perspective. High population growth (3.1% per year), coupled with high fertility (6.6), high knowledge of family planning methods, and high unmet demand for family planning services, all point to the need for continued support to the family planning program. Partly as a result of this analysis, OAR has chosen to support the increased use of modern methods of contraception as one of its strategic objectives in the context of long term planning for the Mission.

The analysis clearly shows that family planning is emerging as a national priority. While an official national policy has yet to be approved by the Government, the MOHP has developed its own policy and standards for service delivery which lay the groundwork for the program.

With the many family planning cooperating agencies working in Togo, the technical assistance capacity is available to support the extension of services beyond the present 15% of health facilities. The project will provide this assistance as well as equipment and contraceptives in support of a major expansion of service delivery capacity.

(vii) AIDS Control

Recent evidence shows that AIDS is an increasing problem in Togo, which will have long term implications for other public health programs. The analysis shows that while other donors are working with the AIDS control program, results so far have been very disappointing as a result of bureaucratic and administrative inefficiencies and sensibilities on the part of the Government. With the recent evaluation of the program, there may be an opportunity for positive intervention.

United States expertise, particularly in the area of epidemiological surveillance may now be appropriate for Togo. As the new program develops, the project will provide the necessary support.

Administrative and Management Consideration

In addition to the specific interventions contained above, management and administrative issues, particularly data collection and analysis, are key foci of this project. To aid in a comprehensive overview of the technical issues of the project, a summary of the administrative and management issues follows:

The technical analysis for this project shows clearly that the MOHP has the capacity and competence to understand and implement public health service delivery programs. The MOHP has been working with USAID and other donors for over ten years in the sector. Trained personnel are available, and Togo has the advantage of various training facilities, including both medical and paramedical schools, which cover the needs of the MOHP.

The MOHP has recently redefined its objectives and developed a policy statement for the health and population sector which emphasizes primary health care, preventive programs, and the development of a national population policy. However, a financial analysis of the Ministry's budget shows that much of the financing for these programs comes from external donors.

To date, external donor (particularly bilateral) funding has been programmed in the traditional way through projects. These projects, including those presently funded by A.I.D., are almost all focussed on specific technical interventions and are implemented through technical divisions of the MOHP. While this

funding has been used appropriately in most cases, the availability of external resources in separate technical divisions at the central level has led to a fragmentation of efforts and various competing interests, with no overall view toward strengthening MOHP systems. The present project has been designed to overcome this problem by concentrating on further reinforcing the technical competence of existing MOHP personnel.

Human Resource Capacity

The analysis further shows that while many health workers are competent in their area of expertise, management and administration skills are often lacking. This is particularly true in a Ministry heavily dominated by medical doctors, with training in highly specialized fields but little background in public health or management. Notwithstanding this fact, it is these same doctors who manage all major divisions and services in the MOHP.

Management Technologies

To address this shortcoming the project will emphasize two aspects of the management system identified as major constraints to more effective resource utilization in the MOHP. These are the development of an integrated health management information system for improved planning and programming, and the development of integrated, multi-purpose prefectural teams to encourage decentralization and better resource management at the prefectural level. (This model is described extensively in Annex E). The proposed improvements follow on progress in areas already achieved under present USAID and other donor funded activities, and build on and utilize information, management, and training technology in which the United States is the acknowledged leader.

Data Processing Capacity

Experience with USAID's CCCD project shows that computer technology can significantly speed up and improve the preparation of health statistics reports to track disease epidemiology in Togo. A limited number of computers have been provided and used at the central level. The MOHP now publishes its yearly health statistics report by May of the following year, a significant improvement from earlier experience where reports either never came out at all, or were delayed for years. With increased sophistication of software use and additional training, the new project proposes to build on these accomplishments. The technical analysis shows that this is appropriate, feasible, and necessary for further progress.

The analysis also reveals, however, that while extension of computer capacity is necessary over the medium term, the project should be prudent in extending it beyond the central level.

Decentralized Management Systems

The necessity of establishing a decentralized management structure in the MOHP is discussed in more detail in the

institutional analysis. It is appropriate in this technical analysis, however, to point out that the development and administration of management systems is an area of acknowledged United States expertise. Technology in this field is well developed, and has been proven to significantly improve administration of both public and private programs in many sectors throughout the world. The development of public health programs in the United States, in general, emphasize program planning and management skills. These are areas of critical need for the MOHP in Togo as revealed in the technical and institutional analyses of this project. Technical assistance expertise in this area is available, and will be used in the project to develop appropriate systems and train Togolese counterparts in the methodologies used.

Conclusion

As presented above, the technical analysis showed that the activities programmed under the project are appropriate and technically feasible. The operational research component of the project will make it possible to continue gathering technical and management information to further refine and reorient the program as implementation proceeds.

C. SUMMARY OF FINANCIAL AND ECONOMIC ANALYSES

The financial analysis of this project demonstrates the sufficiency and timeliness of project inputs and the level and scheduling of recurrent cost obligations for both USAID and the Government of Togo. The economic analysis demonstrates the economic viability and cost effectiveness of project components and major categories of inputs. In addition, it addresses the critical issues of cost recovery, summaries of which have been incorporated in the description of the project elements.

The financial analysis examines the pace of obligations and disbursements and finds them to be reasonable, except for possible delays in FY1993 because of the large volume of project action in that year. The major part of the GOT contribution is for salaries and remains steady over the life of the project. The gradually accelerating participation of the GOT for non-salary recurrent costs seems reasonable as well. The GOT can be expected to offset the bulk of the cost of commodities through cost recovery procedures planned under the World Bank program and this project. There is also the expectation that the ordinary budget contribution for the MOHP will increase over the life of the project, reducing donor dependency for the health sector.

Because of the intangible nature of the benefits accruing from the project, the economic analysis focuses on whether the project inputs are the most efficient and least costly means for achieving project outputs.

The most costly element of the TCSP, Component One, is the long-term technical assistance, accounting for 23 percent of the project. Alternative scenarios were examined, and it was felt that expatriate technical assistance was the most efficient source of management improvements.

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For Component Two, program integration, the most costly item is the short-term technical assistance. However, there are no ready alternatives to it; the pattern is such that the technical assistance will diminish over time, and local institutions will progressively pick up the activities, where appropriate. The second most important input is for medicines and contraceptives; as discussed earlier, these show a declining participation on the part of donors.

For project Component Three, the major cost is expatriate technical assistance to contribute to loosening the regulatory strangle hold on the private sector. When long and short-term TA were evaluated against other models, this was considered the least costly alternative.

A similar analysis holds for Component Four --to expand private sector professional participation in health services delivery. In addition, the project provides for a revolving loan fund which has been demonstrated in many settings to be an efficient and effective use of assistance resources to expand the delivery of health services.

D. SUMMARY OF SOCIAL SOUNDNESS ANALYSIS

The social soundness analysis contains a brief cultural overview of Togo. The most important characteristics noted are its ethnic diversity, the very rapid (3% per annum) rate of population growth, and the unequal distribution of population and wealth over the national territory. While the problems of providing basic health care and education, housing, and employment are on the rise, domestic capacity to address these problems remains very limited.

All proposed project activities have been examined as to their social feasibility and their potential impact on beneficiaries. An overall summary of the analysis follows.

Improved planning and integration of services will permit the MOHP to reduce regional inequalities by a more equitable and judicious distribution of financial resources and a more rational distribution of personnel within the public health sector. The collection and organization of all medical and epidemiological information in the country will permit the identification of priority actions either at the level of diseases or at the level of health problems, or at the level of particularly affected regions. Because of cost savings, this should have a positive impact on all segments of the Togolese population, by increasing availability and equitable access to health care.

However, the cost recovery sub-element deserves special consideration. On the basis of the social soundness analysis, the weak part of the project remains that of the financial contribution of the population to a cost recovery program. More study and research needs to be done and will be done through planned budget-consumption studies. But on the basis of

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available data, only a very small portion, less than five percent of the rural population, will be able to participate in any meaningful way in financing their health care. The implications for preventive rather than curative services is very great.

In regards to family planning, there is strong willingness and desire to practice birth spacing on the part of women, but resistance by the majority of men. Economic constraints are, however, changing the attitude of men on the need to practice family planning.

The analysis also states that services such as vaccination are more likely to be successful in the general population because they require smaller changes in behavior. ORT and family planning by contrast go against strong culturally ingrained patterns which are very difficult to change.

In general, however, the project responds to important socio-cultural issues for the future development of Togo, and has a reasonable chance of success.

Note: This summary is prepared on the basis of a social soundness analysis written in French. A rough translation into English is attached at Annex G.

VII. MONITORING AND EVALUATION

Project monitoring will be a coordinated activity undertaken by all implementing agencies, including USAID, the MOHP and MOF, and NGOs as well as other organizations involved in health services delivery in Togo.

OAR through its HNP office and the GOT through the MOHP will be the primary implementors of this project and will have responsibility for overall monitoring to ensure that the entire project is implemented according to the agreements between OAR and GOT. The OAR/Togo HNP office will be responsible for tracking project benchmarks through reports received from contractors, MOF, MOHP and any special studies, analyses or evaluations.

Monitoring activities will track and assess progress of implementation of project activities and will provide the baseline data required to monitor and evaluate the achievement of benchmarks and eventually the people-level impact of the project. Monitoring will also assess progress towards the stated delivery of project inputs and realization of project outputs. Specifically, the OAR/Togo HNP office will track progress to ensure that:

- * conditions precedent to project start up is fulfilled;
- * long and short-term technical assistance are contracted for and arrive in country on schedule;
- * the performance of technical assistance is adequate;

- * essential commodities are ordered and arrive in country on schedule;
- * appropriate training is provided to the right mix of health workers at the appropriate time;
- * provision of GOT financial and other inputs are on schedule; and,
- * the performance of the MOHP recipients of project inputs.

The GOT MOHP Director General, the chief of Party of the contract Team and the OAR/Togo office of HNP will establish project review and reporting procedures for implementing by the technical assistance contractor and the project implementation entities. These procedures will consist of:

- * Monthly meetings and surveys by the Directeur Général, the Chief of Party and A.I.D. Representative or their representatives in order to address identified impediments early, and thereby minimize their impact;
- * Quarterly reports by all key project personnel using a brief format developed for each personnel category to ensure that all essential matters are reported on, and that problems are anticipated and identified for discussion and resolution;
- * Establishment of a project task force comprised of the Directeur Général and heads of Divisions at the MOPH together with the A.I.D. Representative, the OAR HP officer and the Chief of Party. The task force would meet at least once every six months, to address project progress to date, problems and their resolutions, proposed activities and any other project related actions which may seem necessary for discussion.

EVALUATION

Project evaluations will be managed by the OAR/Togo office of HNP evaluation but with the collaboration and participation of MOHP NGOs, and private sector associations/institutions which participate in implementation of the project.

Annual in-house reviews are planned in order to assess implementation progress, output levels and delivery of inputs. Two external evaluations are planned during the life of project and a final impact evaluation is proposed for lessons learned and to assess progress towards achieving project purpose and goal. Monitoring activities will provide the baseline data for the mid-term and final evaluations.

EVALUATION SCHEDULE

12 months after the signing of the grant agreement, an in-house management review will be held. Subsequent yearly reviews will be held thereafter;

24 months after the signing of the grant agreement, a joint external evaluation will be held;

48 months after the signing of the grant agreement, a joint external evaluation will be held;

72 months after the signing of the grant agreement, a joint final impact evaluation will be held.

The in-house management review will concentrate on management inputs and status of outputs. The two proposed evaluations during project implementation will review and assess:

- * Progress in attaining purpose level objectives;
- * Identifying any management changes required for timely fulfillment of the project objectives;
- * Status of project benchmarks;
- * Adequacy of benchmarks and indicators for assessing overall impact at final evaluation and making recommendations for modification in baseline monitoring, if needed;
- * Technical assistance requirements and progress by the contractor in transferring technical and management skills to the MOHP staff and counterparts to enable them to assume increasingly greater responsibility for project implementation;
- * Overall project management by the grantee, A.I.D. and the contractors;
- * A.I.D. strategy in supporting the identified divisions, especially in relationship to other donor activities;
- * The professional suitability, ability and adequacy of the technical assistance to achieve project benchmarks on schedule and to make mid-course corrections if necessary;
- * The assessment of the level of A.I.D. funding relative to the tasks yet to be accomplished and the degree to which the recurrent costs are being sustained by the GOT;
- * The continuing validity of the project purpose and related objectives and outputs in terms of feasibility and likelihood of sustained beneficial impact;
- * The degree to which women are able to avail themselves of project benefits and participate in project activities;

- * The degree to which information and ideas are being communicated as a result of project outputs, and the extent to which formal and informal linkages among involved entities and individuals have been developed;
- * Institutional relationships; and
- * Collaboration and coordination of other donors.

FINAL EVALUATION

The final evaluation will be performed in the final year before project completion. It will include:

- * Review of the number of benchmarks achieved;
- * Review of progress made in achieving purpose level objectives and progress in realizing inputs and output targets;
- * Assessment of effects on beneficiaries of expanded comprehensive and integrated health services delivery;
- * Assessment of the effects of MOHP assistance to the private practitioners, i.e., loan scheme and revolving fund, credentialling, regulatory and advisory services, training and technical assistance;
- * Delivery of medicines to the rural areas and the functioning of the cost recovery system;
- * Assessment of progress and effects of the integrated services of health delivery or information collection and data use; and,
- * Measurement of selected indicators listed in the end of project status.

The major purpose of the final evaluation will be to assess OAR's role in this sector and to suggest alternative project strategies, if any.

Funds are budgeted for at least two financial reviews and two non federal audits.

REPORTS

The contract team COP will be required to prepare an acceptable work plan 60 days after arriving in country. The plan would cover specific targets for the year including a specific training plan, a half yearly report and a final contract completion report which would incorporate findings of the final evaluation and provides project data and accomplishments through the completion date.

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VIII. CONDITIONS PRECEDENT, COVENANTS, AND SPECIAL PROVISIONS

1) Conditions Precedent to Disbursement

First Disbursement. Prior to the first disbursement under the Grant, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the Grantee shall, except as the Parties may otherwise agree in writing, furnish to A.I.D., in form and substance satisfactory to A.I.D.:

(i) A statement of the names of the persons holding or acting in the office of the Grantee specified in Section 8.2., and a specimen signature of each person specified in such statement.

(ii) A statement of legal counsel confirming that the Agreement, as signed by the Grantee, represents a binding commitment on the part of the Republic of Togo to all of its terms and conditions.

Prior to any disbursement under the Grant for long term technical assistance, or to the issuance of any documentation by A.I.D. pursuant to which disbursement will be made for long term technical assistance, the Grantee shall demonstrate, in form and substance satisfactory to A.I.D., that qualified personnel have been identified and assigned to the following positions on the revised MOHP organization chart, or such other arrangements, satisfactory to A.I.D., have been made to assure functional counterparts for long term technical advisors:

- 1) Director of the Directorate of Planning, and Staff Training
- 2) Director of the Division of Planning;
- 3) Director of the Division of Staff Training;
- 4) Director of the Division of Statistics;
- 5) Director of the Directorate of Finance and Administration;
- 6) Director of the Division of Finance;
- 7) Chief of the Infrastructure Maintenance Service;
- 8) Director of the Directorate of Primary Health Care;
- 9) Director of the Directorate of Health Facilities;
- 10) Director of the Division of Private Health Facilities.
- 11) Director of the Directorate of Pharmacies, Laboratories, and Technical Equipment.

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Additional Disbursement. Prior to the disbursement of any funds under the grant directly to the MOHP, or to the issuance by A.I.D. of documentation pursuant to which such disbursement be made, the Grantee will provide evidence in form and substance satisfactory to A.I.D., that the MOHP has put into place sufficient internal controls and financial management systems to assure that the procurement and accounting functions of the MOHP may reliably undertake contracting and procurement responsibilities under the Agreement.

Notification. When A.I.D. has determined that the conditions precedent specified above have been met, it will promptly notify the Grantee.

Terminal Dates for Conditions Precedent. If all the conditions specified above have not been met within 90 days from the date of the Agreement, or such later date as A.I.D. may agree to in writing, A.I.D., at its option, may terminate this Agreement by written notice to the Grantee.

2) Special Covenants

Project Evaluation. The Parties covenant to establish an evaluation program as part of the Project. The program will include, during the implementation of the Project and at one or more points thereafter: (a) an evaluation of the progress towards the attainment of the objectives of the Project; (b) identification and evaluation of problem areas or constraints that may inhibit such attainment; (c) assessment of how such information may be used to help overcome such problems; and (d) evaluation, to the degree feasible, of the overall development impact of the Project on the rural economy.

The project agreement will also contain a covenant that resources contributed or generated under the agreement shall not be used to aid or facilitate public sector participation in the establishment of prices, or other activities which may likely have the effect of constraining competition.

The project agreement will contain a special provision under which the parties will agree that a private sector revolving loan fund will not be established under the project until adequate financial management procedures for use of the fund are certified by A.I.D. in writing, and approved by the MOHP.

Finally, the agreement will contain a covenant that revenue generated from cost recovery activities shall be used to purchase replenishment stocks of sold products and inputs for the provision of services; revenues received in excess of costs incurred shall be retained at each health facility according to guidelines to be established by the MOHP for reprogramming to improve health services.

IX. ISSUES**A. Donor Coordination**

The Ministry has requested that all the existing work on cost recovery, including studies and pilot experiences be reconciled to assure appropriate uniformity and governmental control. Many different systems have been put in place by different donors over the last few years. This reconciliation will have to be made prior to implementing any extension of cost recovery activities in the new project. This is not only an issue with cost recovery, but an issue across the board. It emphasizes the importance of increased donor coordination, particularly as USAID and other donors move more into the realm of non-project assistance.

B. Sustainability

The design team examined the financial analysis done by World Bank consultants in preparation for the Sector Adjustment Program. Some inconsistencies in the projections, particularly for cost recovery for essential medicines were noted. The team was concerned that the cost recovery program would not be sustainable given the figures presented. An enormous volume of drugs is proposed under the essential drugs program. This issue will have to be cleared prior to USAID involvement in the cost recovery program.

C. Centers for Disease Control (CDC) Role

The MOHP and the Mission have built up substantial relationships with CDC over the period of the CCD project. This assistance has always been of the highest technical quality, with some shortcomings on administrative and management issues. While the project proposes to engage a private sector contractor to provide overall technical and managerial assistance to the project, a role for CDC is still envisioned. The project programs substantial amounts of CDC technical assistance through a PASA. However, CDC in the past has indicated it would not consider providing only short term technical assistance.

