

NGO ASSESSMENT IN TOGO:

Institutional and Technical
Capability Assessment of
Non-Governmental Organizations Active
in the Health and Population Sector in Togo

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The team also acknowledges the devoted hard work of the many NGOs - large or small, national or international, urban or rural - who are working tirelessly throughout Togo to improve the health and well being of the Togolese population. The assessment team hopes that the projects proposed by this report will rapidly develop into practical interventions.

EXECUTIVE SUMMARY: NGO ASSESSMENT IN TOGO

1. Assessment Title: Institutional and Technical Capability Assessment of Non-Governmental Organizations Active in the Health and Population Sector in Togo

2. Objectives: The objectives of Phase II of the NGO assessment were to:

- Select a sample of NGOs for in-depth assessment;
- Assess the institutional capabilities of these NGOs in HPN sector;
- Identify activities NGOs wish to sustain, expand or initiate in the areas of health services, family planning/HIV, and cost recovery/drug supply;
- Identify NGOs capable of contracting with OAR/Togo; and
- Identify options & modalities for AID assistance to NGOs.

3. Methodology: The assessment team reviewed the Phase I NGO inventory, met with partner agencies and NGOs in Lome, visited selected NGOs and health facilities, and discussed options with USAID. The team looked for opportunities to work within the objectives of the current USAID project, Togolese Child Survival and Population (TCSP) to:

- 1) Improve MOHP management; expand public sector health & FP cost recovery;
- 2) Strengthen integrated and decentralized health and FP service delivery;
- 3) Promote public and private sector collaboration in health and FP; and
- 4) Expand and strengthen private sector health and FP service delivery.

4. Findings and Recommendations: USAID has an excellent opportunity to pursue TCSP objectives through NGOs. Since NGOs are relatively more advanced than the GOT in cost recovery mechanisms and in managing integrated health services, they are a logical starting point to encourage decentralized health districts and support systems. The assessment recommends interventions through NGOs to develop pilot health districts, to reinforce health areas, to strengthen the NGO drug supply system, and to increase family planning services.

Health Districts: Four NGO managed hospitals (Afagnan, Agou, Pakals, and Dapaong) are good candidates to establish pilot health districts which could improve access and utilization of PHC services and test the effectiveness of a decentralized management system.

Health Centers: The network of 70+ NGO managed health centers could be reinforced to improve access/utilization of PHC services and to develop population based planning and reporting systems.

Drug Distribution and Cost Recovery Systems: OCDI serves as a source of pharmaceuticals for many NGO health centers. These medicines generate funds to replenish drug stocks and to cover certain operating costs. However, there are weaknesses in drug supply and cost recovery attributable to a lack of resources and inadequate management systems. OCDI needs to improve depot facilities in Lomé, examine the need for depots in Sokodé and Dapaong; and institute more effective procurement, distribution and inventory control; and increase cost recovery through better financial management procedures.

Family Planning/HIV: USAID supports family planning activities to increase the number and quality of service sites, and to assure that all temporary modern methods are available. USAID buy-ins to four cooperating agencies (INTRAH, SEATS, Pathfinder & CARE) are assisting the MOHP to develop technical and support activities to implement a national family planning program. One national NGO, ATBEF, also plays a large role in the program, particularly with regard to contraceptive distribution. Continuation and reinforcement of these efforts is recommended via buy-ins to the cooperating agencies.

ACRONYMS

ADRA	Adventist Development and Relief Agency
ATBEF	Association Togolaise pour le Bien-Etre Familiale (Togolese Family Planning Association)
CHU	Centres Hospitaliers Universitaires (University Teaching Hospital)
CREN	Centre de Recuperation Nutritionelle (Nutrition Recuperation Centers)
CUSO	Canadian University Service Overseas
DANIDA	Danish Foreign Assistance Agency
DED	German Volunteer Corps
DSF	Division de Sante Familial (Family Health Division of the Ministry of Health and Population)
EET	Eglise Evangelique du Togo (Evangelical Church of Togo)
EZE	Evangelical Church of Germany Development Assistance
FAC	Fonds d'Aide et de Cooperation (French Foreign Assistance Agency)
FED	Fonds Europeen de Developpement (EEC Foreign Assistance Agency)
FODES	Federation des Organisations de Development de Savanes (Federation of development organizations of the Savanes Region)
FONGTO	Federation des ONG au Togo (Federation of ONGs of Togo)
FP	Family Planning
GOT	Government of Togo
GTZ	German Development Assistance
HAPSS	Health and Population Sector Support Program
HIS	Health Information Systems
ICCO	Holland Donor Agency
IEC	Information, Education, Communication
INTRAH	Program for International Training In Health
IPPF	International Planned Parenthood Foundation
KAP	Knowledge, Attitudes, and Practices Study
MCH	Maternal and Child Health
MOE	Ministry of Education
MOHP	Ministry of Health and Population
MOP	Ministry of Planning
MSW	Ministry of Social Welfare
NGO	Non-Governmental Organization
OCDI	Organization de la Charite pour un developpement integral (Charitable organization for integrated development)
ORT	Oral Rehydration Therapy
PHC	Primary Health Care
PMI	Programme Maternal et Infantile
PNLS	Programme National de Lutte Contre le SIDA (National Program for the Battle against AIDS)
PVO	Private voluntary organization
SED	Small Enterprise Development
STDs	Sexually Transmitted Diseases
TSCP	Togo Child Survival and Population
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
VDC	Village Development Committees
WHO	World Health Organization

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Acronyms

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Chapter 1: INTRODUCTION

I. INTRODUCTION AND BACKGROUND

A. USAID IN TOGO

The USAID/Togo assistance program has been greatly affected by the continuing uncertain political situation in Togo. Many projects and programs have been suspended while others have been terminated, and the overall program budget has been cut sharply.

In fiscal year 1992 USAID developed an ambitious strategy aimed at laying the foundations for broad-based, sustainable, market-oriented economic growth. Health and Population was identified as the main sectoral focus for this strategy, with improved maternal and child health care and reduced fertility on a sustainable basis as the mission's strategic objective. USAID was to implement this strategy through two complimentary activities: a major technical assistance project, the \$15.5 million Togo Child Survival and Population project (TCSP) and a complementary policy reform program, the \$19 million Health and Population Sector Support program (HAPSS). The HAPSS project was suspended in November 1992. The technical assistance team for TCSP was also been suspended, however, buy-ins to centrally funded family planning projects was able to proceed.

The Office of the A.I.D. Representative (OAR) is currently studying options for the future of its program in Togo. Key among these options is the use of non-governmental organizations (NGOs), both local and international, as avenues through which OAR can channel humanitarian and development assistance to Togo. To fully explore the feasibility of such an option OAR/Togo would like to identify which NGOs are capable of executing the TCSP program activities.

B. OTHER DONOR HEALTH ACTIVITIES

There is little coordination among aid agencies in Togo. An emphasis on vertical programs, and the lack of a clear strategic plan by the Ministry of Health and Population (MOHP) for coordination of partners, has resulted in a fragmented approaches in the health sector.

Programs are often donor-led with little coordination taking place. Consequently the management of PHC and MCH/FP programs funded by USAID, GTZ and UNFPA has so far not been integrated into the MOHP's management system, thereby raising the issue of sustainability (WB, 1991).

Table 1 indicates the diversity of interests and types of assistance of aid agencies. Various donors have expressed interest in working through NGOs. FAC, FED and World Bank have financed a few micro-projects for various development activities. While there has been interest expressed to and by NGOs to fund similar projects through their organizations, very little is actually being done at this time.

Table 1
TYPES OF ASSISTANCE FROM AID AGENCIES

PARTNER AGENCY	PRIMARY FOCUS	SECONDARY FOCUS
WORLD BANK	Policy & Organization Reform	<ul style="list-style-type: none"> • Drug procurement • Training • Infrastructure Renov.
ADB: African Development Bank	National Drug Procurement	<ul style="list-style-type: none"> • Infrastructure Renov.
FED: European Development Fund	Commodity Import Program	<ul style="list-style-type: none"> • Infrastructure Renov. • FP/HIV
USAID	Family Planning and Health	<ul style="list-style-type: none"> • Training • HMIS • Health Services Access
FAC: French Foreign Assistance Agency	Policy Reform	<ul style="list-style-type: none"> • EPI (motos) • Infrastructure Renov. • HMIS • Scholarships
GTZ	Community Level Cost Recovery	<ul style="list-style-type: none"> • Training • CHU TA • AIDS
OMS	Oncho Control	<ul style="list-style-type: none"> • Training • Program evaluation
UNICEF	Bamako Initiative	<ul style="list-style-type: none"> • EPI • Training • Health Services Access
UNFPA	Family Planning	<ul style="list-style-type: none"> • IEC
UNDP	Rural Development	<ul style="list-style-type: none"> • Assistance to NGOs
CUSO: Canadian Univ. Services Overseas	Rural Hydrauliques	<ul style="list-style-type: none"> • EPI training
CATHOLIC (MISEREOR)	Hospitals & Dispensaries	<ul style="list-style-type: none"> • Community Development
PROTESTANT (ADRA, EZE)	Hospitals & Dispensaries	<ul style="list-style-type: none"> • EyeCare (Glei)

UNICEF's Bamako Initiative is strengthening community-based pharmacies which carry an inventory of 30 essential drugs and which are governed by Village Development Committees (CVD'S). NGOs, like Iles de Paix and CONGAT, who are working with government dispensaries are collaborating with this effort. UNICEF plans to set up a total of 295 village pharmacies throughout the Maritime, Plateau and Savanes Regions.

GTZ, the German organization for technical cooperation, has been assisting the MOH set up a cost recovery program in the Central Region. An initial supply of generic drugs have been provided to 12 village pharmacies. GTZ will be working with the FAC to expand cost recovery activities to all health centers and dispensaries in the Plateau and Central Regions.

To date, except for the funding of some microdevelopment projects, no large scale donor funding through NGOs has been organized. Because most of the programs of assistance are through the MOHP, donors are not sure whether assistance to NGOs can be programmed through existing projects, or whether entirely new project structures will be required.

The purpose of the NGO assessment, in two phases, is to help USAID, and other donors, determine the operational capabilities of PVO and NGO groups that are currently working in the field of health and population.

C. PHASE I: NGO INVENTORY

The Phase I assessment completed an inventory of NGOs and PVOs operating in Togo with health and population activities. Information regarding geographic location, size, resource base and funding sources, current and future activities, and their relationships with donors, the Government of Togo (GOT) and other organizations was collected. The team also visited centers of OCDI (Organization de la Charite pour un Developpement Integral). and EET.

Phase I was carried out by a three independent consultants, Ms. Samuela Bell, Mr. Aben Ngay (for the first two weeks) and Mr. Atcha Djobo (for three weeks). The team:

- Collected and examined existing lists of NGOs/PVOs
- Determined which NGOs/PVOs had health and population activities
- Compiled a working list of NGOs/PVOs with health and population activities
- Designed a work and travel plan for upcountry interviews and site visits.
- Met with the Regional Medical Directors to identify additional NGOs
- Visited NGOs and health facilities in each of the 5 regions
- Interviewed each NGO/PVO using a questionnaire designed by the team

The Phase I inventory is to be made available to other aid agencies and NGOs as a separate document in both English and French.

D. PHASE II : NGO ASSESSMENT

The objectives of Phase II of the NGO assessment are to:

- Select a sample of NGOs for in-depth assessment;
- Assess the institutional capabilities of these NGOs in HPN sector;
- Identify activities NGOs wish to sustain, expand or initiate in the areas of health services, family planning/HIV, and cost recovery/drug supply;
- Identify NGOs capable of contracting with OAR/Togo; and
- Identify options & modalities for AID assistance to NGOs.

The NGO assessment team was composed of Dr. Franklin Baer, team leader and health service/NGO specialist, Ms. Eileen McGinn (family planning specialist), Dr. Arthur Legacé, health economist, and Ms. Samuela Bell who conducted the Phase I inventory.

Phase II of the NGO assessment included the following activities:

- review of the Phase I inventory
- meetings with the partner agencies and NGOs in Lome
- visit to the CARE regional office at Atakpame
- field visits with NGOs and health facilities at:
 - Regional Medical Directors of Plateau and Savanes
 - OCDI office in Sokode and Dapaong
 - Red Cross Dispensary at Kichéridé & Baga Centre Medico-Socio
 - Ile de Paix, OCDI, Congat, & ATBEF offices in Dapaong
 - Glei, Agou, Tsiko and Afagnan hospitals
- two day conference of family planning agencies at Atakpame (Plateau)
- discussions with USAID about funding mechanisms for specific projects
- review of the first draft with USAID

Chapter 2: PHASE I INVENTORY AND SELECTION OF NGOS FOR PHASE II

A. THE PHASE I NGO INVENTORY

1. An Overview

The Phase I team was successful in interviewing all ten international NGOs (referred to in this report as PVOs) and 18 of 22 national NGOs. The team made site visits (or interviews) to 35 OCDI centers nationwide out of a possible 45 centers and site visits to 5 of 19 protestant managed health facilities. Information on 28 NGOs is shown in Table 2.

There were some complaints encountered of what could be termed "survey overload" and discouragement that there had been numerous surveys and studies conducted by donors which had yet to result in increased assistance to NGOs. For the most part the NGOs and centers gave their responses cordially but some had comments to make pertaining to the above. One major OCDI center, Afagnan Hospital, declined to give the interview citing they were too busy to answer any more surveys (but later accepted to meet with the phase II team).

The team also encountered national NGOs who did not actually have ongoing activities in the health and population sector. Generally, these were smaller PVOs, Clubs, and Associations had received a one-time donation for a health related activity and were searching for additional project funding. The common thread of these agencies is a lack of core funding.

2. Umbrella NGOs

FONGTO: The Federation des ONGs au Togo has compiled a listing of 88 NGOs of which 49 comprise its membership. FONGTO provides an interface between its members and the Togolese government. It does not serve as an umbrella structure for joint planning or funding of NGO activities, as each NGO deals directly with its partner agencies.

EET: The protestant NGOs are often collectively referred to as the EET (Eglises Evangelique du Togo). This has been, and still is, often confused with the EET, the Evangelical (Presbyterian) Church of Togo. This report distinguish between the two by using EEPT for for the Presbyterian church and EET for the collective work of the protestants.

EET does not yet function officially as an umbrella organization to medical work, and there is actually little contact between the three protestant hospitals even though they are all situated in the Plateau region. There is, however, a meeting scheduled for mid-October 1993 to propose a more organized association of protestant churches. The five protestant churches with health related activiies are as follows:

- 1) SDA: Seventh Day Adventists manages the ophthalmological hospital of Glei.
- 2) ABW: Association of Baptists for World Evangelization have a hospital at Tsiko.
- 3) SMB: Southern Baptist Mission manage a health center of Morétan
- 4) AG: Assemblies of God is building a health center at Kane near Notse
- 5) EEPT: Evangelical Presbyterian Church of Togo manages the Agou hospital and a dispensary network of 18 dispensaires and health posts.

OCDI: OCDI functions as an association of automous health facilities and not as a coherent health services delivery system. Membership includes 49 Catholic facilities located

throughout the four dioceses. The organizational structure extends from the parish to the diocese and ultimately to the national level. Governance is achieved through a national board which includes diocesan representatives, while regional coordination is achieved through diocesan committees. The governing body of OCDI formulates triennial nationwide strategic plans for the organization and specific annual plans for OCDI national staff. Program coordination is achieved through an annual meeting of all members held each November and through quarterly meetings with health facility representatives held in each diocese.

The activities of OCDI are grouped into three major service areas; emergency humanitarian assistance; community motivation (animation) and training; and human services and development. Projects include a broad range of activities in agriculture, animal husbandry, water, support to artisans, development of small enterprises, education and health services.

The major roles played by the national OCDI office are the operation of the drug distribution system and the planning and coordination of church supported health services in the four dioceses. This coordination is achieved through an annual meeting held each November, attended by representatives of each Catholic health facility, as well as by representatives of the MOH. This meeting is used to address issues of common interest and to formulate general plans for the next year. A number of E.E.T. health facilities hold what might be called associate membership in OCDI.

FODES: In the region of Dapaong the NGOs have organized themselves into a regional federation called FODES (Federation des Organisations de Developpement de Savane). This organization meets once a month to coordinate activities in the region. Discussions are limited primarily to technical topics. There is no integrated regional or prefectural health action plan established by FODES. Improved coordination of NGOs based on the health area as a unit for planning, reporting and coordination should be encouraged.

3. Major NGOs

For the most part, the Phase I study did not reveal any big surprises as to which International NGOs are the major actors in the health and population sector. Certainly CARE has the most extensive projects in the areas of Family Planning and AIDS despite their relatively recent entry into these areas. CRS plays a large role in supporting health care delivery through their financial and technical assistance to OCDI National and the provision of medicines and food to that organization. In the area of rural health education and village pharmacies, PLAN International, World Neighbors, and Ile de Paix play major roles in the regions in which they work. However, PLAN International has said that it cannot enter into a contract with USAID following directives from PLAN headquarters.

As for National NGOs, the largest organization of non-governmental health care delivery centers in the country is OCDI National with 45 centers nationwide. A second, affiliated but separate, church-sponsored NGO, E.E.T., has 19 centers including a large full-service hospital among its membership. Most health care centers with religious affiliation are members of either E.E.T. or OCDI. Croix Rouge Togolaise has 35 health posts and 18 Centres Medico-Sociale throughout the country. ATBEF (Association Togolaise Pour le Bien-Etre Familial) is the most prominent PVO actor in family planning services and contraceptive distribution. On the level of village health education and village pharmacies, CONGAT plays a large regional role through their projects in the Savane region.

Table 2
NGOS BY TYPE OF FUNDING SOURCE, REGION AND HEALTH ACTIVITY

Abbrev.	Type	Act93	REGIONS													
			L	M	P	C	K	S	Out	FP	HIV	NUT	CUR	PRE	FAC	HIS
NGOs Working in ALL REGIONS:																
BF	PVO	YES	L	M	P	C	K	S	YES	-	-	Nut	-	-	Sup	-
CRS	PVO	YES	L	M	P	C	K	S	NO	-	-	-	-	-	Sup	-
T.H.	PVO	YES	L	M	P	C	K	S	NO	-	-	Nut	-	-	Sup	-
ATBEF	NGO+	YES	L	M	P	C	K	S	YES	S+E	HIV	Nut	Cur	Prv	Sup	HIS
RedCross	NGO+	YES	L	M	P	C	K	S	YES	Edc	HIV	Nut	Cur	Prv	Sup	HIS
OCDI	NGO+	YES	L	M	P	C	K	S	YES	-	-	Nut	-	-	Sup	HIS
NGOs Working in LOME:																
Colombe	NGO-	YES	L	M	-	-	-	-	YES	Edc	HIV	Nut	-	-	-	-
BlueCross	NGO-	YES	L	-	P	-	-	-	YES	Edc	HIV	-	-	-	-	-
CARRE	NGO-	YES	L	-	-	-	K	-	NO	Edc	HIV	-	-	-	-	-
ECHOPPE	NGO+	YES	L	-	-	-	-	-	YES	Edc	HIV	Nut	-	Prv	-	-
FAMME	NGO+	YES	L	-	-	-	-	-	YES	S+E	HIV	Nut	Cur	Prv	-	-
APER	NGO-	NO	L	-	-	-	-	-	NO	-	-	-	-	-	-	-
ATOLSI	NGO-	YES	L	-	-	-	-	-	YES	Edc	HIV	-	-	-	-	-
CACIEJ	NGO-	YES	L	-	-	-	-	-	YES	Edc	HIV	-	-	-	-	-
NGOs Working in MARITIME:																
Colombe	NGO-	YES	L	M	-	-	-	-	YES	Edc	HIV	Nut	-	-	-	-
E.E.T.	NGO+	YES	-	M	P	C	K	-	YES	S+E	HIV	Nut	Cur	Prv	Sup	HIS
CARE	PVO	YES	-	M	P	C	-	-	YES	Edc	HIV	-	-	-	Sup	HIS
AG	NGO+	YES	-	M	-	-	-	-	YES	Edc	HIV	Nut	-	-	-	-
NGOs Working in PLATEAU:																
E.E.T.	NGO+	YES	-	M	P	C	K	-	YES	S+E	HIV	Nut	Cur	Prv	Sup	HIS
CARE	PVO	YES	-	M	P	C	-	-	YES	Edc	HIV	-	-	-	Sup	HIS
+Bleue	NGO-	YES	L	-	P	-	-	-	YES	Edc	HIV	-	-	-	-	-
AVE	NGO+	NO	-	-	P	-	-	-	YES	-	-	-	-	-	Sup	-
CERAD	NGO+	YES	-	-	P	-	-	-	YES	-	-	Nut	-	-	Sup	-
NGOs Working in CENTRAL:																
E.E.T.	NGO+	YES	-	M	P	C	K	-	YES	S+E	HIV	Nut	Cur	Prv	Sup	HIS
CARE	PVO	YES	-	M	P	C	-	-	YES	Edc	HIV	-	-	-	Sup	HIS
N-S	PVO	YES	-	-	-	C	-	-	YES	Edc	HIV	-	Cur	Prv	Sup	-
PLAN	PVO	YES	-	-	-	C	-	-	YES	Edc	HIV	Nut	-	-	Sup	-
Islam.	NGO+	YES	-	-	-	C	-	-	NO	-	-	-	Cur	Prv	-	-
NGOs Working in KARA:																
E.E.T.	NGO+	YES	-	M	P	C	K	-	YES	S+E	HIV	Nut	Cur	Prv	Sup	HIS
CARRE	NGO-	YES	L	-	-	-	K	-	NO	Edc	HIV	-	-	-	-	-
SAR	NGO-	NO	-	-	-	-	K	S	NO	-	-	-	-	-	-	-
A&A	PVO	YES	-	-	-	-	K	-	YES	Edc	HIV	Nut	-	-	Sup	-
W.N.	PVO	YES	-	-	-	-	K	-	YES	S+E	HIV	Nut	-	-	Sup	-
NGOs Working in SAVANNAH:																
SAR	NGO-	NO	-	-	-	-	K	S	NO	-	-	-	-	-	-	-
I.P.	PVO	YES	-	-	-	-	-	S	YES	-	-	Nut	-	Prv	Sup	-
CONGAT	NGO+	YES	-	-	-	-	-	S	YES	Edc	HIV	Nut	-	Prv	Sup	-
JARCF	NGO+	YES	-	-	-	-	-	S	YES	-	-	-	-	-	Sup	-

B. SELECTION OF NGOS FOR PHASE II ASSESSMENT

The NGO phase I inventory identified 28 NGOs with health related activities. From this information it was possible to assess that some of the NGOs manage activities which are only marginally related to health care services, are too small to manage large inputs of direct USAID assistance (the possibility of indirect assistance was not excluded), or had clearly indicated that they were not interested in USAID funding for their programs.

The assessment team was informed that NGOs were becoming tired of the numerous visits and surveys to assess their potential. Given the uncertainty about USAID funding in Togo, USAID also did not want to raise expectations of providing assistance through NGOs. Selection criteria were applied, therefore, to identify NGOs who might be the candidates for direct funding by USAID. NGOs who satisfied two or more of the following criteria factors were included in the sample:

- Management of a primary health care or child survival program;
- Provision of family planning services;
- Provision of a support service of national scope, e.g. essential medicines;
- Provision of technical assistance to other NGOs. e.g. for family planning;
- Management of a hospital or similar sized infrastructure;
- Management of a population-based program of more than 20 villages;
- Links to a U.S. support base or funding source; and
- Management of an annual budget exceeding \$100,000

Applying these selection criteria to the 28 NGOs identified by the phase I inventory resulted in 13 NGOs which met the selection criteria for two or more factors.

Table 3
SELECTION OF NGO FOR ASSESSMENT STUDY

Abbrv.	Agency	Total	PHC	FP	Nat.Prog	TA>NGO	Hosp	Vill	US sup	Budget
OCDI	Organiz. de Charite pour Develop. Integral	*****	PHC	-	EM	Yes	3	20+	Yes	100+
-	Protestant Churches of Togo	*****	PHC	FP	-	Yes	3	40+	Yes	100+
ATBEF	Assoc. Togo. Pour le Bien-Etre Familial	*****	-	FP	FP	FP	-	-	Yes	100+
CARE	CARE International	****	-	FP	-	-	-	20+	Yes	100+
CRS	Catholic Relief Services	****	-	-	Nutritio	Yes	-	-	Yes	1million+
Pathfin	Pathfinder	****	-	FP	-	FP	-	-	Yes	100+
PLAN	PLAN International	***	-	-	-	-	-	50+	Yes	100+
W.Neigh	World Neighbors	***	-	FP	-	-	-	14	Yes	100+
BorneFo	BORNEFONDEN	**	-	-	Sponsors	-	-	-	-	1million+
CONGAT	Conseils de Gestion Afrique Togo	**	PHC	-	-	-	-	32	-	<100
Croix R	Croix Rouge Togo.	**	PHC	-	-	-	-	20+	-	<100
I.Paix	Ile de Paix	**	PHC	-	-	-	-	42	-	<100
Terre d	Terres des Hommes	**	-	-	Handicap	-	-	-	-	100+
ECHOPPE	Assoc. d'Aide aux Artisans du Tiers-Monde	*	PHC	-	-	-	-	-	-	-
Islam.	Centre Medico-Cultural Islamique	*	PHC	-	-	-	-	-	-	<100
FAMME	Forces en Action Pour...Mere/Enfant	*	-	FP	-	-	-	-	-	<100
Nord-Su	Nord-Sud Developpement	*	PHC	-	-	-	-	10+	-	<100

Additional information from the phase I inventory indicated that two NGOs (PLAN and World Neighbors) stated that they were not interested in funding from USAID, and that two other NGOs

were providing a service of national scope which was only marginally related to the delivery of health services (Terre des Hommes' work with handicapped children and Bornefonden's work with child sponsorship program). Pathfinder currently has not projects in Togo, but is to be supported through a "buy-in" for family planning. The assesement of Pathfinder in this report is therefore limited to the family planning. It was decided, therefore, not to include these NGOs in the phase II assesement of NGOs. However, the possibility of indirect funding through another NGO for a group like Terre des Hommes or some of a smaller "one star" family planning NGOs was be given consideration in the formulation of recommendations and options.

The NGOs selected for study during phase II were:

- Organization de Charite pour Development Integral (OCDI)
- Protestant Church Hospitals of Togo
- Association Togolaise Pour le Bien-Etre Familial (ATBEF)
- CARE International (CARE)
- Catholic Relief Services (CRS)
- Conseils de Gestion Afrique Togo (CONGAT)
- Croix Rouge Togolaise
- Ile de Paix
- Pathfinder (family planning assesement only)

Chapter 3: NGO INSTITUTIONAL AND TECHNICAL CAPABILITIES

A. HEALTH ACTIVITIES

1. Overview of Health Service Organization in Togo

Togo's network of public health infrastructure consists of some 2000 health posts and 600 dispensaries at the village level, 70 health centers and 16 hospitals at the district/prefectoral level, and five regional hospitals. A reorganization of administrative boundaries from 21 to 31 prefectures resulted in existing health centers being appointed as prefectural hospitals. The organization of health services has been aptly summarized in two reports:

The Ministry of Public Health is a highly centralized institution, with both major and minor decisions being made in Lome, often by the Minister himself. Almost all programmatic, personnel and budgetary decisions are made at the central level. The subdistricts at the prefectural level are managed by the Medecin Chef, who has very little authority or discretionary power over programs, personnel or budgets.

This centralization is compounded by the fragmentation of the Ministry into a series of relatively isolated vertical programs such as EPI, malaria, and MCH. These programs rarely coordinate their activities. Training activities are often duplicated and poorly coordinated. Different programs often place competing demands on the health provider's time at the dispensary and health center levels. Each program has distributed separate reporting forms, compounding the recording and reporting problems at the periphery without assisting coordination and integration at the central level.

Most donor activity has reinforced this fragmentation by providing separate budgets and technical assistance for vertical programs, with little incentive or support for integrating mechanisms. (USAID Health Sector Analysis, 1990)

Togo's health care system and population planning program face serious structural problems. Chief among these are inadequate integration of the eight components of PHC at the level of each facility and serious disfunction in the referral system. Operational norms are lacking and treatment protocols do not exist. No outreach strategy is in place to ensure that the most vulnerable groups, particularly women and young children, benefit from available services. (World Bank, 1991)

The TCSP project paper states that:

After extensive policy dialogue on the subject [of Health Sector Restructuring] with the World Bank, the Government of Togo envisions a comprehensive restructuring of the MOHP in support of improved service delivery. The key elements of restructuring are decentralization of management; horizontal integration of programs; MOHP budget adjustments; expansion of family planning; and expansion of private sector health services. (TCSP PP, 1991)

This NGO assessment examines the potential of using NGOs to achieve these objectives.

2. NGOs by regional infrastructure, focus and development strategies

a. Regional Infrastructure and Focus

The table below indicates the areas of health focus for the selected NGOs. Discussion of the Health Information System (HIS), family planning (FP) and HIV are dealt with in later sections of this report.

Table 4
NGOS BY TYPE OF FUNDING SOURCE, REGION AND HEALTH ACTIVITY

Abbrv.	Type	Act93	REGIONS														
			- L	M	P	C	K	S	-	Out	FP	HIV	NUT	CUR	PRE	FAC	HIS
OCDI	NGO+	YES	L	M	P	C	K	S	-	YES	-	-	Nut	Cur	Prv	Sup	HIS
E.E.T.	NGO+	YES	-	M	P	C	K	-	YES	S+E	HIV	Nut	Cur	Prv	Sup	HIS	
RedCross	NGO+	YES	L	M	P	C	K	S	YES	Edc	HIV	Nut	Cur	Prv	Sup	HIS	
ATBEF	NGO+	YES	L	M	P	C	K	S	YES	S+E	HIV	Nut	-	Prv	Sup	HIS	
CARE	PVO	YES	-	M	P	C	-	-	YES	Edc	HIV	-	-	Prv	Sup	HIS	
CRS	PVO	YES	L	M	P	C	K	S	NO	-	-	Nut	-	-	Sup	-	
CONGAT	NGO+	YES	-	-	-	-	-	S	YES	Edc	HIV	Nut	Cur	Prv	Sup	-	
Ile Paix	PVO	YES	-	-	-	-	-	S	YES	-	-	Nut	Cur	Prv	Sup	-	

All NGOs provide some degree of support, directly or indirectly, to health facilities. NGOs involved in service delivery including a mix of curative and preventive care include OCDI, EET, Red Cross, CONGAT and Ile de Paix. NGOs involved in preventive services, primarily family planning, include Pathfinder, CARE and ATBEF. CRS support has been primarily through MCH feeding centers within the Ministry of Social Action. The actual management of health facilities is discussed later in this section.

Nutrition activities are conducted by most of the NGOs. In most cases these are integrated as part of a health care program. The exception to this is the CRS program which managed a feeding program through MCH growth monitoring/feeding centers and in primary schools. This program has been stopped since 1992 because of the general strike, and was replaced by emergency food distribution through OCDI. These efforts are targeted at the elderly, handicapped, widows, orphans and refugees. In other words the CRS nutritional interventions are based primarily on social problems which may aggravate an already precarious nutritional status.

Many of the NGOs have community-determined health services in the form of Postes de Secours, Case de Santé, or Red Cross stations that are staffed by volunteers or locally trained health workers. While these efforts are commendable they need to be "linked" to primary health facilities (dispensaries or health centers) for effective referral, logistical support, technical supervision, and recognition by the MOHP. With respect to NGOs, this linkage is easiest when the primary health facility is managed by the NGO themselves rather than by the government. Examining the distribution of NGO managed health facilities at the dispensary level are therefore logical points for the development of community-based outreach programs.

The regional distribution of the health infrastructure managed by NGOs is shown in the Figure 1 and Table 5. (INSERT MAP HERE). This clearly indicates the predominance of

three NGOs, OCDI, "EET", and Red Cross in NGO management of health facilities. While other NGOs, such as Nord-Sud are managing one or two health centers, they do not merit serious consideration for direct grants from USAID. However, they should certainly be given an opportunity to receive subgrants as part of an umbrella project to assist health centers.

Table 5
Regional Distribution of NGO Managed/Assisted Health Facilities

NGO	REGIONS	FOCUS	Hosp	HC/disp	GOTdisp	CS/PS
OCDI	L M P C K S	PHC	5	27 HC/disp	14 PMI	3 PS
"EET"	- M P C K -	PHC/FP/HIV	3	8 HC/disp	-	11 PS
Croix Rouge	L M P C K S	PHC	-	19 disp	-	35 CS
ATBEF	L M P C K S	FP	-	1 clinic	-	-
CARE	- M P C - ?	FP/HIV	-	-	50 disp	-
CRS	L M P C K S	Nutrition	-	-	91 MCH	-
CONGAT	- - - - - S	PHC	-	-	2 disp	14 CS
Ile de Paix	- - - - - S	PHC	-	-	4 disp	42 CS
Pathfinder	L - - - - -	FP	-	-	-	-

OCDI manages five hospitals, two (Afagnan and Dapaong) of which could be considered fully functional with medical doctors and surgical capability. Afagnan is clearly the busiest and best functioning NGO managed hospital in Togo. With 250+ beds, it nearly always functions at, or above, capacity. The energetic staff have found time, however, to develop community outreach programs at 28 health posts, but now realize that this efforts needs to be consolidated and linked to intermediary health centers. They have proposed, and have MOHP agreement in principle, to create and manage a health district for the subprefecture within which they are situated. This includes a population of 60,000, however, their location on the Togo-Benin border certainly impacts a much larger population.

The OCDI Dapaong hospital concentrates on pediatric care in conjunction with the nearby government hospital which takes care of adult care. This same division of labor (pediatric vs adult) is repeated in the numerous PMI centers of OCDI which are often located next door to government dispensaries. OCDI manages two dispensaires and ten PMI clinics in the prefecture of Daogong. Congat and Ile de Paix each support and manage two state dispensaries, while Red Cross manages three health facilities.

The other three OCDI hospitals, Pagala, Aledjo and Kante, are staffed by medical sisters, but no doctors. They offer excellent quality of care for the services which they provide, but are hesitant about becoming overwhelmed by any expansion of services which might involve a health district or the presence of a medical doctor.

The three "EET" hospitals may all be considered fully functional and appear to have a well functioning infrastructure, although Agou hospital is beginning to show its age. Each of these hospitals is managed by a separate denomination. Agou is managed by the Evangelical Presbyterian Church, Tsiko by the Baptist for World Evangelization, and Gleï by the Seventh Day Adventist Church. While all three hospitals are situated in the Plateau region, there is actually little contact or exchange of information between them.

The Gleï hospital specializes in ophthalmology and wishes to pursue this specialty on a regional and national basis rather than developing a health district. The Tsiko hospital currently has no community outreach work, and is more interested in developing and sustaining its curative care. The Agou hospital had a guinea worm/MCH mobile team

outreach work funded by World Neighbors for several years, but operations ceased when funding was no longer available. The EEPT network of dispensaries is scattered throughout several regions, but not in the immediate area surrounding the hospital. Agou is interested in developing a health district which would include ten government dispensaries and a population of 100,000.

b. NGOs by development strategy

David Korten has proposed a classification of NGOs by development strategies. Three of these generations are shown in Table 6. While this approach seems to imply that third generation strategies should be the objective of NGOs, it is important to recognize that there is an appropriate time and place for each approach. In a time of a national crisis or famine first generation "Relief and Welfare" strategies by some NGOs are the most appropriate, while others NGOs may at same time be support community outreach approaches.

First generation strategies include relief efforts, feeding programs, hospital-based or dispensary-based curative care. Few public health-related activities, if any, are included such as well baby clinics and nutrition rehabilitation centers. The CRS funded MCH feeding centers and the Baptist managed hospital at Tsiko (Plateau) is a good example of first generation medical work.

Second generation strategies generally move from a hospital or dispensary into the community, often with mobile teams and village health workers to promote community development work and perhaps to establish health huts/posts. The mobile team approach of Agou, the network of health posts established by Afagnan (which bypasses existing state dispensaries) are examples of second generation strategies.

The third generation strategies could include the organization of health districts as part of a national health system of collaboration between PVOs and the government. Afagnan's proposal to consolidate its 28 health posts with the five government health centers and to link referral, management and supervision to Afagnan as the reference hospital/health district office is the best example of a third generation strategy.

Table 6
DEVELOPMENT-ORIENTED NGOS: THREE STRATEGIES

	FIRST Relief & Welfare	SECOND Community Development	THIRD Sustainable Systems Development
Problem Definition	Shortage	Local Inertia	Institutional & Policy Constraints
Time Frame	Immediate	Project Life	10-20 Years
Scope	Individual or Family	Neighborhood or Village	Region or Nation
Chief Actors	NGO	NGO plus community	All Relevant Public & Private Institutions
NGO Role	Doer	Mobilizer	Catalyst
Management Orientation	Logistics Management	Project Management	Strategic [systems] Management
Development Education	Starving Children	Community Self-Help	Constraining Policies and Institutions
Examples	Feeding center Hospital care	Mobile teams NGO health posts	Afagnan/Agou health district
NGOS	CRS EET:Baptist EET:ADRA ATBEF CARE	Red Cross Congat Ile de Paix CARE OCDI: Aledjo Baga	OCDI: Afagnon EET: Agou OCDI: Dapaong

adapted from Korten D., *Getting to the 21st Century*, Kumarian Press, 1990, p.117.

3. Interrelationships with the MOHP

There is considerable diversity and confusion in the terminology used by the MOPH and NGOs in describing service delivery sites. These include: Centre Medico-Socio (CMS/MOPH and CMS/RedCross versions), health center, dispensary, clinic, health hut, PMI (Protection Maternal and Infant), MCH center (CRS), Center Village (CONGAT's strategy for collective outreach), CREN- Nutrition rehabilitation centers, Boites pharmaceutique and USP (Unité de Service Peripherique).

The administrative limits of the canton are generally used by the MOHP and NGOs to define the zone of responsibility for each dispensary. However, since this does not always correspond to a logical or practical geographical division for health work, a canton may be divided into two health areas, or a health area may include a village from a neighboring canton.

While the principle of population-based health care is understood, it has not been used effectively in planning health services or in coordination of NGOs. There are no regional or prefectural or subdivisional maps or village lists indicating the respective health areas of dispensaries. There are no long-term written action plans for the prefecture/subdivision district to guide the coordination and expansion of health services.

In addition there exists some interesting but confusing combinations of NGO activities within the same health center area which may result in a duplication or triplication of efforts. For example the dispensary of PANA includes a state dispensary and personnel for fixed curative care, a separate PMI run by catholic sisters for pediatric care, and a CONGAT mobile team (based at DAOPONG) for outreach strategies beyond the 5km "limit" of the dispensary.

Given the confusion of terminology concerning the service units, it may be wise to uniformize and base planning on "health areas" (aires sanitaires) rather than on dispensaries, health centers, PMIs or USPs. One, and only one, health facility in each health area would be responsible for the coordination of the medical work and for reporting to the subdivisional level. This facility should have at least one qualified nurse (State or NGO affiliated), and could retain a diversity of labels. The subdivision should therefore plan in terms of a number of 20 health areas rather than in terms of 10 health centers, 5 dispensaries, 2 CMS, and 3 USPs.

Coordination of NGO assistance should be based on partnerships with the health area rather than "NGO zones". Optimally an NGO would be able to provide the spectrum of assistance required to assist in the development of a health area. If all NGOs to provide such assistance, USAID could fund assistance to assist in the development of xx health areas which would include a mixture of those assisted by IP, CONGAT, Red Cross, and OCDI.

While the Savanes region, for example, has considerable potential for the development of an integrated health system with strong community development, any project funded by USAID should be conditioned on the preparation of a long term written plan of action, preliminary mapping of health areas, and strategy for coordination of NGOs activities to health areas.

4. Management capacity

The capacity NGOs with respect to managing health service delivery and/or support systems is evaluated and summarized with respect to their capacity to manage a health district, health area or a support component, e.g. drug supply system.

Table 7
HEALTH SYSTEM MANAGEMENT CAPACITY

NGO	Health District	Health Area	Support System
OCDI	***	***	**
CRS	-	-	***
CARE	-	-	***
ATBEF	-	-	**
RED CROSS	*	**	-
CONGAT	*	*	-
ILE/PAIX	**	***	**
Pathfinder	-	-	**
AGOU	**	**	*
AFAGNAN	***	***	**

- = not applicable, * = little, ** = good, *** = very good

5. Opportunities for reorientation, expansion and sustainability

In looking for opportunities to work through NGOs it is important to keep in mind the proposed objectives for the TCSP project:

- 1) Improve MOHP management, and expand public sector health & FP cost recovery
- 2) Strengthen integrated and decentralized health and FP service delivery
- 3) Promote public and private sector collaboration in health and FP
- 4) Expand and strengthen private sector health and FP service delivery

Developing Health Districts: USAID has an excellent opportunity to pursue the objectives of TCSP through assistance to NGOs. In fact a good case can be made that since NGOs are relatively more advanced than the GOT in cost recovery mechanisms and in managing integrated decentralized health service delivery that they are the logical starting point to initiate the development of health districts. Togo, like many small countries, talks "decentralization" but doesn't really know how to "let go". It would be much easier for the MOHP to first "let go" of a health district managed by an NGO. Once a functional health district model is established, the MOHP could then extend the same type of autonomy to state managed health districts.

The best candidate for management of a health district is an NGO which:

- is a national NGO, not an international PVO (for sustainability reasons)
- manages a hospital (established credibility, infrastructure, mgt capacity)
- a geographical area which can be easily "delimited" into a health district
- is active in community development health work
- has a network of health centers in the immediate hospital area
- has the vision and interest for developing a health district
- is able to collaborate with other NGOs in the area

Based on the management capacity analysis, it is evident that OCDI/Afagnan and EEPT/Agou are the best candidates for developing health districts. The development of a health district around Dapaong would necessitate a more complicated collaboration among NGOs to assist the MOHP. It is an alternative development model for health districts which should also be pursued.

USAID funding of the health districts of Afagnan, Agou, and Dapaong could provide the models of autonomy which would break the chain of centralized management, promote decentralization and develop integrated health services within the context of the objectives of TCSP.

Reinforcing Health Centers: A significant percentage of the Togolese population utilizes NGO managed health facilities. Only some of those facilities have active outreach activities into the surrounding communities, and fewer still are managing their activities with respect to a clearly defined health area. There are at least 70 known health centers, dispensaries, PMIs or health posts being managed by NGOs (see table below). Taking into account facilities managed by smaller NGOs and by community groups, it would be possible to envision an USAID-funded intervention to reinforce the activities of 100 NGO managed health centers, and improve PHC services for an estimated 500,000-700,000 people in all regions of Togo.

Assistance to NGOs managing health centers would involve a "subgranting" process which would permit an NGO project to provide assistance to small NGOs for certain activities or in support of one or two health centers.

B. SUPPORT SYSTEMS: HIS, DRUG SUPPLY, COST RECOVERY

This section examines NGO capability as it relates to specific support systems: health information, drug supply and cost recovery. While these systems are examined to the extent that they exist in the NGO's included in the sample, the study focuses primarily on NGO's which are directly involved in health services delivery. Information on public sector drug procurement and health care financing, including recent cost recovery initiatives, is found in ANNEX C.

1. Health Information Systems.

a. General.

Table 8 summarizes the overall organizational capability of the NGO's in using information for management purposes. The organizations have been assessed on their ability to collect and store data, produce technical reports, interpret and use data, and share information. These activities have been rated on a scale of 1 (weak) to 5 (strong). The assessment is based on the preliminary inventory of these organizations, site visits and interviews with key staff.

Table 8
INFORMATION SYSTEM MANAGEMENT CAPACITY

NGO	COLLECT AND STORE DATA	TECHNICAL REPORTS	INTERPRET & USE DATA	SHARE INFORMATION
OCDI	3	2	2	4
CRS	4	4	4	4
CARE	4	4	4	4
ATBEF	3	2	2	3
RED CROSS	3	2	3	3
CONGAT	3	2	2	4
ILE/PAIX	3	3	3	4
PROT HOSP	4	4	4	4
AFAGNAN	4	4	4	4

Given the diversity of these organizations and their roles, it is difficult to comment on the implications of their relative strengths and weaknesses. For example, because CRS is not a direct provider of health services it does not have a health information system as such; nevertheless, it is clearly capable of interpreting and using data for management purposes.

Because NGO's were selected for the second phase of this study on the basis of criteria indicative of organizational capability and scope of activities, it is not surprising that the NGO's surveyed collect data on their operations, prepare periodic reports and share information through these reports and through meetings with member facilities, other NGO's and various GOT directorates. One common weakness, especially among smaller organizations, is the inadequate capability to analyze and interpret data and to make appropriate use of readily available information in program

management. CRS, CARE, AFAGNAN and the Protestant hospitals were on the whole the most capable organizations surveyed and exhibited the greatest information management capacity. As seen below, OCDI has been very effective in sharing information through its annual meetings.

b. The Use of Health Information by NGO Health Care Facilities.

While it was beyond the scope of this study to perform an exhaustive survey of HIS capacity in NGO health facilities, findings on HIS activities in NGO facilities sampled during the first phase of the study are summarized in Annex C (Table C.1) and are discussed in the following paragraphs.

Population-based data. While there has yet to be a formal delineation of service areas in Togo, NGO facilities do have a general idea of the population which they serve and the villages which they cover. However, the lack of an adequate database precludes sound health planning and program monitoring. For example, a medical director stated that immunization data for certain sites reflected coverage levels in excess of 100%, which would indicate either overcounting, overvaccinating or use of the wrong population base in calculating immunization levels. Such obvious errors raise questions regarding the validity and value of other data generated by the HIS.

Internal use of data. As a group, the NGO hospitals have more sophisticated management systems and tend to use some operational data, e.g., utilization, cost and revenue, as inputs in the management process. However, most health centers fail to make effective use of utilization data and other available information even when they have compiled it for submission to the MOHP.

The MOHP reporting system. Most health centers surveyed indicated that they submit monthly reports to the MOHP. These include individual reports ranging in length from one to three pages. These documents reflect the activities of the health facilities in various vertical programs as is outlined below:

- The monthly disease report (new cases of 50 diseases disaggregated by sex & age)
- Prophylactic and therapeutic use of chloroquine
- Diarrheal disease report
- Prenatal/postnatal consultations and births
- Immunizations by antigen and age group
- Cases discharged (for centers with beds)
- Growth monitoring

Additionally, facilities which receive contraceptives from ATBEF prepare a stock report which is sent directly to ATBEF.

The reporting system reflects the high level of centralization and emphasis on vertical programs found within the MOHP. Unfortunately, this is also indicative of the fragmentation of services existing at the health center level. As was observed at some health centers visited during the study, prenatal visits may be scheduled on one day and postnatal visits on another. One room may be used for vaccinations, another for growth monitoring. Yet these services are provided to the same group of mothers and children by the same members of the health center staff. The integration of these activities would make life much easier for both the patients and the staff.

Because the formats of the source documents, registers, etc., are inconsistent with reporting formats, preparing reports is unnecessarily time-consuming and complex, and there is a high probability of error in data compilation. The validity of the reports is further compromised by the questionable accuracy of data entered onto source documents because of the lack of standard definitions and

protocols. While health workers exert considerable effort in the preparation of the reports, they seldom use the information they compile as a tool in managing their facilities.

Within the MOHP, there is no mechanism to verify the receipt of reports and to ensure reporting compliance. Some data are consolidated into annual reports, but it is unclear if or how much of the information is utilized. There is no provision of routine feedback within the system. Because of the fragmentation of the reporting process it is difficult to see how the data can be used effectively for integrated program management at the local, regional and national levels.

Other. Several of the facilities submit annual reports to their donors, frequently the religious congregation which subsidizes their operation. It was also evident from their responses that most of the facilities consider the annual OCDI meetings an effective way to share information. Discussion usually focuses on a specific theme of mutual interest and concern selected by the participants. These meetings are attended not only by the Catholic health facilities, but also by the Protestant facilities and by representatives of the MOH.

c. Opportunities for Reorientation, Expansion and Sustainability.

Ideally, a health information system should provide a facility with: (1) population-based data, i.e., demographic, socio-economic and epidemiologic data for program planning, monitoring and evaluation; (2) operational data (utilization of specific health services, costs, revenues, progress toward objectives), which can be used for internal management; and (3) a reporting system, which provides higher organizational levels with information necessary for program planning and management.

The information utilized should be the minimum necessary to ensure achievement of organizational objectives. Terminology and formatting should be standardized to maximize data validity and to simplify the compilation and analysis of data. Staff at each organizational level should utilize information generated by the system in the management of the organization.

Restructuring the MOHP reporting system briefly described above is being addressed within the broader context of health sector reform and is beyond the scope of activities being proposed in this document. However, there are a number of possible interventions within the scope of activities proposed in Chapter IV, such as the provision of technical assistance and training to NGO health facilities, which could improve health services delivery by helping staff make better use of operational data. There is considerable interest in receiving this kind of assistance.

Using Available Data More Effectively. Data routinely compiled in the preparation of monthly MOHP reports could easily be used as an input in the internal management of health facilities. Simple analyses of readily available data could yield useful information regarding the incidence of various illnesses, trends in utilization and progress toward program objectives. This could facilitate a more proactive role on the part of NGO health facilities and reduce dependence on information coming from higher echelons.

Demonstrating the Use of Population Based Data. The development of the proposed pilot health districts would permit the delineation of health service areas and the concomitant derivation of population-based data as a basis for program planning, monitoring and evaluation. For example, information on the service area population could provide the basis for projecting births, deaths, prenatal visits, postnatal visits, deliveries, and immunization workloads.

Improving Inventory Control and Financial Management. Improving the drug supply system and improving cost recovery activities in NGO facilities will also require the compilation and analysis of information on drug consumption, health services utilization, costs and revenues. Sound inventory control and financial management require that transactions be accurately documented and that this information be used in day to day management.

Improving Supervision. Supervisory practices could be improved through the more effective use of operational data, such as the analysis of trends and the comparisons of drug consumption and costs across health facilities serving similar populations.

2. Drug Supply in NGO Health Facilities.

a. OCDI and Protestant Health Facilities.

The operation of its drug procurement and distribution system is one of OCDI's most important activities. Drugs are purchased from IDA using funds contributed by the Catholic Medical Mission Board, other donations, or obtained through sales and are then sold to member health facilities, both Catholic and Protestant, at a slight mark-up to cover shipping costs and the operation of the depot. A list of products currently available through OCDI may be found in ANNEX C.

A problem cited by Dr. Tagore, who is responsible for drug distribution, and by the centers which depend on OCDI for supplies is the unreliability of the drug distribution system due to delays in procurement and occasional stock outages. Larger facilities, such as AFAGNAN and AGOU-NYOGBO, which purchase large quantities of pharmaceuticals, have chosen to import directly rather than obtain drugs through OCDI. There is a general consensus, both within and outside the organization, on the existence of these problems and on the actions necessary to resolve them. The major obstacle is the lack of resources. There is a need for more adequate warehouse facilities, especially if the role of the depot is to be expanded.

The depot currently shares a truck with all of the other sectors within OCDI. Another truck would greatly facilitate drug distribution. The depot is also understaffed; additional personnel are needed if the system is to function effectively. There is also a need to increase inventory levels to ensure adequate minimum stock levels to reduce the probability of outages.

However, increasing resources will only solve part of the problem. There is also a need to improve management procedures relating to projecting drug consumption, procurement practices, inventory control, financial management and budgeting. More effective operation of the depot in Lomé also depends on improved management practices at both the diocesan and facility levels.

While OCDI is a major supplier of drugs to member facilities, it is not the sole source for these institutions. This is clearly reflected by the results of a survey of Catholic facilities reported in ENQUETE DIAGNOSTIC DES BESOINS DES SERVICES DE SANTE DE L'EGLISE CATHOLIQUE AU TOGO (Juillet 1993) and summarized in Table 9.

While 41 of 44 facilities included in the survey utilized the OCDI depot, 28 purchased drugs from TOGOPharma and 6 from private pharmacies, which handle primarily proprietary drugs. This would indicate either poor purchasing practices by the facilities or difficulty in getting drugs through the OCDI system. Among the problems cited by the facilities were distance from the OCDI depot, lack of transportation and inadequate funds for drug purchases.

Table 9
Drug Sources Used by OCDI Facilities

Drug Source	# of Facilities
OCDI	41
TOGOPharma	28
MEDEOR (Germany)	16
Donor Contributions	12
Private Pharmacies	6
GTZ	3
Other *	18

*MissionPherme, Health Subdivisions, ACCTM, Lions Club, Order of Malta, Hopital Saint Camille, Caritas Italienne, Pharmpro and MEMISA

b. NGO Hospitals.

AFAGNAN, AGOU-NYOGBO, TSIKO and GLEI purchase most of their drugs directly from overseas sources. AFAGNAN uses a number of different suppliers. The director of the pharmacy indicated that drugs were imported from Italy, where their religious congregation is based, IDA, or from the "Centrale d'Achat de Cotonou" in Benin, depending on which source had the lowest price. AGOU-NYOGBO receives a German subsidy of 30 million FCFA which permits it to purchase needed pharmaceutical through IDA. TSIKO indicated that it obtains some of its drugs from IDA, but that it is heavily dependent on donated drugs from the U.S. GLEI obtains its pharmaceutical products from CBM in Germany.

c. Village Pharmacies.

A major thrust of the cost recovery initiatives undertaken in the public sector and supported by some NGO's has been the establishment of community-based pharmacies managed by village development committees (CVD's). In most instances these pharmacies have received initial drug stocks from GTZ, UNICEF or another donor and have set up revolving drug funds. However, the sustainability of these pharmacies is threatened by the unavailability of low cost generic drugs with which to replenish their inventories. Representatives of the Croix Rouge Togolaise in Lomé cited this problem as the most serious confronting village pharmacies serving their facilities.

d. Opportunities for Reorientation, Expansion and Sustainability.

Improving the Effectiveness of the Drug Supply System. The first step in improving the drug supply is to determine the configuration of the modified system. Options include:

- Maintaining the current configuration.
- Adding regional depots, e.g., at Sokodé and Dapaong.
- Creating a decentralized system in which regional depots procure drugs directly from suppliers.
- A combination of the above options.

An example of the last option would be a system with OCDI serving the lower four regions, possibly

with a regional depot at Sokodé, and an independent depot in Dapaong serving the Savanes region. This approach could easily be coordinated with the pilot health district proposed for the Savanes region. It is anticipated that the pilot health districts around AFAGNAN and AGOU-NYOGBO hospitals would be supplied directly by those institutions, although they could purchase from OCDI.

While maintaining the existing system may be the easiest option to pursue in the short run, the model just outlined would be more responsive to local needs, not necessarily more expensive, and probably more sustainable in the long run. Regardless of the configuration selected, there is a need to determine who can use the system in order to project sales volume, to set minimum inventory levels and to determine reorder cycles. System expansion should be implemented in an orderly manner, with planned increases in inventory to accommodate higher sales volume. Unplanned expansion could overextend the system and result in chronic stock outages.

While it is not necessary to impose a uniform inventory management system on facilities using the supply system, the facilities should meet minimum criteria regarding:

- Provision of clean, orderly and secure drug storage.
- Effective inventory control procedures.
- Ability to project consumption and to replenish stock on a regular basis.

3. Cost Recovery in NGO Health Facilities.

a. Current Cost Recovery Activities.

Table 10 summarizes cost recovery activities among the NGO's included in the study. NGO's directly involved in health services are the most active in cost recovery, although in some cases NGO's provide some support to village pharmacies associated with their activities. Cost recovery in NGO health facilities is discussed in greater detail later in this section.

Table 10
COST RECOVERY ACTIVITIES OF NGOS

NGO	SUMMARY OF COST RECOVERY ACTIVITIES
OCDI (See Annex C)	Most facilities charge for drugs and/or services.
CRS	Good financial management system. Monetizes Title II foodstuffs for program funding.
CARE	Initiated contraceptive sales in cooperation with MOHP & ATBEF.
ATBEF	Requests small participation fee, 4but does not cover costs.
RED CROSS	Drugs are sold by village pharmacies associated with their health centers.
CONGAT	PMI services free, but village groups charge 10 FCFA to help cover costs.
ILE DE PAIX	Some activity with village pharmacies for 4 HC's it is assisting in Savanes.
Prot. Hospitals (See Annex C)	Rely heavily on fees and drug charges for revenues. Agou-nyogbo is 70% self-supporting)
Afagnan Hosp. (See Annex C)	Flat fee of 1000 FCF^ /day covers 25% of IP costs. Overall, 30% of costs are recovered.

NGO health facilities have been engaged in some form of cost recovery throughout their existence. However, it is mostly in recent years, when confronted by rising costs and increased difficulty in raising sufficient funds through contributions, that these charitable institutions have realized the need to generate revenues through patient fees.

As shown in Annex C (Tables C.2 and C.3), there are significant differences in cost recovery among these facilities. Hospitals, with their higher costs and more sophisticated management systems, have more formalized billing and collections procedures. For example, AFAGNAN relies on patient revenues to cover about 30% of its total operating costs, while AGOU-NYOGBO indicated that its collections finance nearly 70% of its operating expenditures.

Among health centers, attitudes regarding charging patients for services vary considerably, as do billing practices. Some facilities have separate charges for drugs, consultations and procedures while others charge a flat fee for all services or simply request a contribution from those deemed capable of paying. However, staff in many of the facilities visited during the first phase of this study expressed an interest in improving their cost recovery procedures.

b. Opportunities for Reorientation, Expansion and Sustainability.

The effectiveness of cost recovery activities could be enhanced by improving financial management at the drug depots and the health facilities. While the project should not impose a standardized system on all facilities, it should assist the facilities in designing and using systems consistent with their needs and capabilities. Every attempt should be made to design the simplest system consistent with sound financial practices. At a minimum, the system should include provisions for:

Financial Planning. Effective financial planning is a key factor in improving cost recovery. Facilities must determine which costs are to be financed through drug charges, e.g., replacement drug costs, shipping charges, losses, and pharmacy staff salaries. This information provides the basis for determining the mark-up needed to cover the operating costs of the drug depots and the health facility pharmacies.

Control of expenditures. Expenditures should be properly authorized following facility policies.

Accounting/Bookkeeping. The accounting system has two basic functions - 1) accurately document financial transactions and reflect financial status and 2) incorporate adequate internal control mechanisms in order to minimize the risk of error, loss or theft. These include:

- * Minimizing access to cash;
- * Depositing daily receipts intact;
- * Use of a bank or postal account;
- * Control of cash disbursements;
- * Frequent and consistent reconciliation of accounts;
- * Periodic independent verification of accounts; and
- * Adequate documentation to permit tracing transactions from source to financial reports.

While no financial management system is foolproof, the design and use of a system which adheres to the criteria outlined above permits the prompt detection of inconsistencies attributable to error or loss. This in turn facilitates the correction of these problems on a timely basis and also serves as an effective deterrent to theft. There are a variety of cost recovery currently in use which meet these criteria. With appropriate training and technical assistance, NGO facilities could adapt these systems and thereby improve their cost recovery activities.

C. FAMILY PLANNING AND HIV ACTIVITIES

1. Overview of FP/HIV and organizations in Togo

The demographic and health information for Togo is quite similar to many other countries in the developing world. The birth rate is very high (estimated to 45 per thousand), maternal mortality is very high (estimated 400 to 700 per thousand in different studies), natural rate of increase approaches 3 per cent, all of which give the population a very young structure, with about 50% of the population under 15 years of age. It is estimated that there are 770,000 women of reproductive age and 600,000 children under 5. The only reliable data since the 1981 census was generated in the 1988 study of health and family planning Beliefs and behaviors.

The 1988 Demographic and Health Survey conducted in Togo showed that about 90 per cent of the women knew at least one method of family planning after prompting while 40% knew one spontaneously; that 34% of the women were currently using a family planning method but only 3.5% were currently using a modern method. The rest were using mainly post-partum abstinence, withdrawal and periodic abstinence (most did not correctly describe the fertile period). The total fertility rate was 6.6 children per woman. Women over 30 wanted about 6 children while women under 30 wanted about 5. Infant mortality was 85 per thousand and 0-5 child mortality 158 per thousand which was lower than in 1977 (206) but about the same as 1982 (159).

In terms of family planning services in the country, the first institution to promote family planning activities in a systematic way in Togo was the Association Togolese pour le bien-etre familial (ATBEF), an affiliate of the International Planned Parenthood Federation (IPPF). ATBEF was formed in 1975 and since that time has initiated activities in all five regions of the country. ATBEF has traditionally performed three important activities in the country: it supplies contraceptives to all family planning service delivery sites, collects the (monthly or quarterly) reports on the utilization of the products and produces the material for information, education and communication. ATBEF also runs a community based distribution program throughout the whole country with one motivatrice per prefecture. In addition, ATBEF has a clinic in Lome where practical training in clinical family planning methods can take place. ATBEF also supports other broader development activities related to responsible parenthood, women's development and youth guidance.

Since 1986 and with USAID's 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 this, the government of Togo issued a call for a nationwide effort to promote the health of women and children through family planning and to allow couples to determine the number and spacing of their children. A Division of Family Health was begun in 1990 to coordinate the government's family planning efforts. In 1990 the Ministry of Health and Population prepared guidelines for use in the promotion of family planning at its own facilities. In 1991, the Ministry of Health and Population issued a policy on family planning's important role in promoting the health of mothers and children.

As a result of these events, the United States Agency for International Development (AID) has assisted the government in initiating/expanding family planning activities by means of the Togo Family Health project (1977-1985) and the Family Planning International Assistance Togo 02 project (1983-1986), as well as via Family Health Initiatives II (1987-1992). Also USAID/Lome and the Ministry of Health and Population (MOHP) have invited several technical agencies to start work in Togo in concert with the government in the country's 21 (now 30) prefectures (INTRAH, SEATS, Pathfinder, CARE, AVSC, The Futures Group, JHPIEGO). Complementing these is assistance from

other bilateral, multilateral, national and local agencies which have become active in family planning in different parts of the country. The United Nations Fund for Population Activities (UNFPA) in particular has been active in the two regions of Maritime and Kara in terms of assisting the government to introduce these services into the health facilities.

There is a great diversity among the partners as to the type of components and subcomponents of family planning activities funded (equipment, supervisory staff, training of traditional or other birth attendants) in all of these projects, as well as a difference in the type of facility where they intervene in the health care delivery system (regional hospital, health center, dispensary). Also some agencies perform very specialized functions (INTRAH for training) while others are flexible in providing various types of assistance. Some work mainly through the government system while some work only with non-governmental organizations (NGOs) and some can work with either.

In general, most of the methods available in Togo until very recently were barrier methods (condoms and spermicides) which could be widely provided by villagers with some minimal training (community based distribution). With the cooperation of all partners, the number of sites where clinical methods were available has grown. It was estimated (by INTRAH) that in August 1993 there were 84 health sites in the country where personnel trained in all hormonal methods were available and 50 where IUDs were available in addition to hormonal methods. These 84 sites were distributed among the five regions as follows: Maritime (33), Plateaux (11), Centrale (5), Kara (32), Savannes (4). See Annex " Different Centers for FP in Togo". (Note that all documents which say "all methods" are available actually mean all temporary methods, not including male or female sterilization.) Recently in one region (Plateaux), a CARE centrally funded family planning project has assisted in the training of government staff in an additional 50 dispensaries in the use of hormonal methods (pills and injections) and 20 of them will be trained in the insertion of IUDs. The three Protestant hospitals also offer services (Agou, Tsiko, Glei) as do a few of their dispensaries.

In sum, it is evident that the family planning program in Togo is a young one in the stages of initiation of systems required for its maintenance and success: training of providers, selection and equipping of centers, supervision, IEC, information systems, and operations research. The climate in the country toward family planning is a fairly conservative one still. There are signs that this is changing particularly among the youth, but there is much work to be done to make family planning a household word in Togo. Table 13 provides a view of the various family planning players in the country and their various roles.

In terms of HIV/AIDS, the GOT was not very quick to act in part because the epidemic has been little felt in Togo. In fact, several service providers and other health workers say that many people do not believe in the reality of AIDS because it has not been widely seen here. Nevertheless, the GOT formed a National Program for the Battle against AIDS (PNLS) in 1988. The program is situated in the MOHP with oversight by a committee of representatives from other ministries. The objectives of the program were to: educate the public, provide condoms, protect the blood supply, identify and follow-up on high risk groups and conduct epidemiological research. In January 1990 a meeting was held to determine the amount of funds needed for AIDS programs on a national scale. Since most of the donors have suspended aid to Togo, the program has obviously suffered.

Table 13
PUBLIC AND PRIVATE SECTOR FAMILY PLANNING ACTIVITIES IN TOGO

	PUBLIC SECTOR	PRIVATE SECTOR
CARE	<ul style="list-style-type: none"> • current PPFT project: trained 40 male nurses and 40 female assistant birth attendants in 40 dispensaires in Plat in hormonal methods; trained for IUDs in 10 of these dispensaires, another 10 shortly; all training (theoretical and practical) done in Plat • trained 100 male volunteers from local areas in distribution of barrier methods; have been trained for pill re-supply but awaiting GOT approval • PROTECT project to be funded with USAID buy-in (Oct. 1 start projected): to support 24 dispensaries in Plat and 15 in Sav for reproductive health care; train 39 staff one from each; supply EQ for deliveries and pre-natal care; supports 30-40 volunteers in Plat & 80 in Sav; ATBEF gives contracp except Noristerat 	
ATBEF	<p>supplies all service delivery sites with contraceptives except Noristerat; regional coordinators receive reports from all centers on contraceptive use; provides technical assistance to other agencies especially in IEC and reaching youth</p>	<p>current: clinic in Lome for FP and curative care; youth center in Notse; production of IEC materials for general public and for adolescents on FP and related topics (AIDS, sexuality, responsible parenthood); 31 motivatrices, one per prefecture currently supported by SEATS; proposes to continue this activity with USAID funds after evaluation; proposes to support Red Cross cases de sante in 35 villages (29 of which are in Plat) aided by a a mobile team; two proposals pending for recommend. of an evaluation team</p>
FED		<p>support trg and salary of motivatrices in 3 prefectures of Sav thru ATBEF</p>
INTRAH	<p>conducted trg needs assessment in all regions; TOT for national team; set standards of service & protocols for providers/sites in conjunction with MOHP (DSF); developed trg curricula for 2'l methods and for TOT; introduce FP into professional school (mid-wives, physicians)</p>	

	PUBLIC SECTOR	PRIVATE SECTOR
UNFPA	IEC programs in schls for FP & AIDS; 75 centers opened in Mar & Kara since 1989 project started; 2 supervisors in place; providers trained; supply all centers of Togo with Noristerat	
SEATS	original activities: revise HIS to include MCH activities on same reporting form; initiated pilot activities for quality assurance in 9 Lome centers; supply eqp to 30 clinic in Plat, Centr & Sav; + 3 vehicles buy-in (start late 1993): assist 60 centres de sante with EQ in Plat, Ctl, Sav; support a regional MCH/FP supervisor in each of 3 regions; need to program INTRAH assistance for training service providers	supply ATBEF with some contraceptives; support 31 motivatrices thru ATBEF, one per prefecture to do IEC and distribute barrier methods; awaiting GOT go-ahead to sell re-supply of pills; assist 2 CHU with construction and training (again with INTRAH help); provide mini-lap EQ to CHU and Be Maternity; assist ATBEF with analysis of its HIS and supply system
Path finder		integrate FP into 3 TOP clinics; 3 CNSS clinics (postponed); youth project in Lome to be designed
EET		provide FP services including tubal ligation at two hospitals (Agou and Tsiko) and on request at one hospital (Glei); certain dispensaries in Plat also offer services
Red Cross		has proposal FP with ATBEF assistance; pending with USAID for 35 cases de sante, 29 of which are in Plat; awaiting ATBEF eval results
CACIEJ		works with students in CEGs and university got FP and AIDS education; may be included in Pathfinder youth project
FAMME		works with prostitutes and women baggage carriers on FP and AIDS; have three volunteer MDs who give two hours a week each in small clinic; creating IEC messages for this particular group

The program initially gave out testing kits but they were too few to test all those that the providers thought needed testing. It seems that they are mainly used to test blood donors. The program has not been able to re-supply the hospitals in anything like an organized manner. The program has put out some stickers and posters which one sees in service sites and hotels. Condoms are available in virtually all MOHP sites in all regions of the country thanks to the family planning distribution system. Practically all the family planning agencies claim to have AIDS discussions at the end of family planning group sessions. Some sentinel groups are being studied and it was reported that 15% of pregnant women tested positive for HIV at the University Teaching Hospital in Lome in a recent 1993 study.

CARE has had a project for HIV/AIDS in Lome since 1990, funded by the World Health Organization, France's bilateral program (FAC), and CARE (France). USAID assisted the project when FAC suspended aid. The target group is travellers who are waiting in bus or taxi depots. Thirty-eight drivers were trained to give group talks and to sell condoms. The project has expanded to the Centrale region where 22 drivers have been trained in three main towns. CARE has designed and drafted an AIDS project which is to be submitted to USAID for an extension of the activities into other groups such as prostitutes and students, and into all regions of the country. CARE will work with FAMME, a group which has already made a solid entry into the community of prostitutes in Lome. SOMARC would give the project a credit for condoms, which would be sold by the drivers and prostitutes. The project does not plan to deal with sexually transmitted diseases (STDs) but CARE might look into this possibility. SOMARC is managing the social marketing project for condoms which are being sold widely for about double the cost of the non-marketed condoms.

There was no feeling in the family planning community nor among other private service providers that there was a serious effort being made around AIDS. With the disruption of the government activities in the recent past, this is not surprising. Table 14 provides a look at the AIDS activities described here.

Table 14
PUBLIC AND PRIVATE SECTOR HIV ACTIVITIES IN TOGO

SECTOR AGENCY	Public Sector	Private Sector
CARE		<ul style="list-style-type: none"> ● current: with drivers in Mar and Centrale for IEC and sale of condoms ● planned early 1994: with drivers in all regions and prostitutes and students near bus/taxi stations
SOMARC		social marketing project country-wide
FAMME		<ul style="list-style-type: none"> ● current: volunteer work with prostitutes and baggage carriers from the market in Lome ● planned: collaborate with CARE project reaching students

The following are summaries of the major important facts about and major activities of the agencies discussed.

a. CARE: has been in Togo since 1987 working in health and agroforestry. The family planning activities started in 1991 when CARE/USA received a central cooperative agreement from AID/W. AIDS activities began in 1990 with contributions from CARE France, the World Bank and FAC. The AIDS office is in Lome and the family planning office is in Plateaux. Another family planning project is starting October 1993 in Savannes and Plateaux and an AIDS continuation project will begin January 1994 in the whole country.

CARE's mandate is to work in the GOT's peripheral health structures (dispensaries) in the Plateaux region to make all modern temporary methods available to the community. In two years, all the 50 programmed dispensaries have already begun to offer services and demand is said to be rising. The project's staff worked in the community to minimize any backlash.

. In the project starting in late 1993, additional services in reproductive health (pre-natal care, delivery, post-partum care) will be offered at dispensaries in the Plateaux and Savannes, still at the peripheral dispensary level.

The CARE health staff numbers 20 persons in both offices plus 150 volunteer field agents in Plateaux. Of the 20, about half are support staff and half professionals. A few additional staff are planned for the AIDS continuation project. CARE is new to family planning as its first project was as noted in 1991. In addition, there is no full time medical staff member who can assist in difficult problems, complications of methods and technical updating of nursing and midwifery staff.

b. INTRAH: is a training group based in North Carolina and situated at the medical school of the university campus at Chapel Hill. INTRAH has had many AID contracts and cooperative agreements over the years, and currently has the family planning training agreements for all three regions. The francophone Africa office is situated in Lome and works in six countries to assist in family planning training: training of trainers, training of service providers, development of curricula, etc. There are experienced trainers and clinical personnel (nurse, obstetrician-gynecologist) available in Lome to provide required expertise.

c. SEATS: is a centrally funded project awarded to John Snow, Inc. in 1989 that has as its objective to work in the countries with the lowest contraceptive use and least developed infrastructures to develop family planning programs. Although most of its work is in Africa, it also has worked in Papua New Guinea. The regional office for SEATS has been in Togo since 1989 but recently the office is in the process of moving to Senegal. A sub-regional office for Togo and Benin will continue in Togo.

In Togo SEATS has funded various things: equipment, needs assessments, technical assistance for the University Hospital Center. It also funds the 31 motivatrices from the ATBEF program, one for each prefecture. ATBEF and SEATS are reviewing the experience of CARE in using volunteers and may add volunteers to the staff of motivatrices.

d. Pathfinder: is one of the oldest family planning agencies since their work started in the 1950s. They have had many contracts, cooperative agreements, and buy-ins from AID and funding from other sources. Pathfinder makes an real attempt to raise private funds. Pathfinder has just started to identify and write up projects in Togo. A youth center in Lome and integrating family planning services into the private clinics of the largest firm in Togo are their plans for the next year.

e. ATBEF: is a member of the International Planned Parenthood Federation (IPPF). ATBEF began in Togo in 1975 and broke the ice for family planning in the country. It had to sell the idea of family planning to couples, government officials, even doctors and health

professionals. They also were able to make barrier methods available to couples through MOHP service sites all over the country. They are still charged with importation and distribution of contraceptives, and most service sites still send reports to regional ATBEF coordinators as they have been doing for years. ATBEF has a clinic in Lome where practical training takes place during clinical training; it has a youth center in Notse; and produces IEC materials for their programs. ATBEF also is charged with supervision for the activities of 31 motivatrices, one in each prefecture.

Traditionally, the role of the family planning associations is to take on new and perhaps controversial activities, ones the governments would not be able to take on publicly. ATBEF has not performed this role recently, and has also been overshadowed by the arrival of the CAs. ATBEF will be evaluated by USAID in October-November 1993 to determine their management capacity and the type of technical assistance which would be most useful to them. ATBEF is just re-establishing itself after the height of the crisis when it was virtually absent from the country for nine months (of the strike).

2. Regional distribution of NGOs by FP specialty

The activities of the various partners are shown in the following table (Table 15) by region. It can be seen that much of the activity of NGOs is focused in Plateaux and Savannes. Savannes was chosen by some agencies because it is the least endowed region in terms of family planning/HIV infrastructure. Plateaux was chosen by some because decentralization was thought to have the best chance to succeed here. Maritime and Kara were the two regions where the UNFPA were working since 1989 and no special efforts were made there by the USAID-funded agencies. Of course with Lome in Maritime, there will necessarily be much activity there.

3. Interrelationships with other NGOs and the MOHP

As can be seen from the various tables and as has become clearer during this analysis, the different NGOs are working in different regions and/or with a different type of service facility or with a certain functional area of expertise. As is clear also, most of the work is with the MOHP, rather than the private sector. The NGOs meet with the chief of the family health department of the MOHP and with each other on a fairly regular basis. For example, in January 1993 the NGOs met with MOHP and USAID to work out a unified program for the year late 1993 to mid-1994. Each agency produced its year's plan after common discussions and agreements were made concerning the different activities to be accomplished.

In terms of HIV/AIDS, the major NGO is one of the family planning agencies (CARE). The other is a small agency which is basically running on volunteer time and money (FAMME). They have already met several times and are planning to work together in the future in CARE's next HIV/AIDS project. Both of these agencies work with the private sector. SOMARC is also working in the private sector in social marketing.

Table 15
REGIONAL DISTRIBUTION OF FAMILY PLANNING ACTIVITIES

REGION AGENCY	MARITIME	PLATEAUX	CENTRALE	KARA	SAVANNES
CARE		40 dispen 100 vol new: 24 disp 40 vol			new: 15 dispen 80 vol
ATBEF distrib all USAID IPPF contrect; seven regional coordin	clinic Lome; Notse youth center; one motivatr per prefectur	new: 29 cases de sante with Red Cross; one motivatr per prefectur	one motivatr per prefectur	one motivatr per prefectur	one motivatr per prefectur
SEATS revise HIS form with MOHP	support 9 quality of care ctrs in Lome	supply EQ to health centers support FP supervisr	supply EQ to health centers support FP supervisr		supply EQ to health centers support FP supervisr
INTRAH Trg cur- ricula, standards for service delivery	trained 15 nat'l trainers; set up practical trg centers Lome				
Red Cross		29 cases de sante with ATBEF			
FED					3 motivat
EET		3 hosppls and a few dispen			
CACIEJ	FP education for students in Lome				

4. Management capacity: planning, personnel, logistics, finances

The management capacity of CARE, SEATS, INTRAH, and Pathfinder resides partly in the local Togo (or African) regional offices and partly in the headquarters' offices in the United States. These agencies have been managing USAID (and other) funding for years and most have received their USAID central funds through the competitive process. They are thoroughly familiar and competent in dealing with USAID requirements. For example, when the Togo office's financial accountability fell below what its headquarters' staff knew it should be, they sent a financial officer from Washington to live in Togo and provide necessary accountability and technical assistance to local staff. They have the capacity to identify and hire technical or management staff from the U.S., Africa or anywhere else. The staff of the NGOs in question is very experienced and very sophisticated in family planning program planning and management.

The management capacity of two new organizations FAMME and CACIEJ is unknown as these two organizations are basically working on donations and volunteered time. They will need to work under the umbrella of another agency to learn requirements and procedures.

The ATBEF as the leading national family planning agency has performed its chief roles over time mainly in contraceptive distribution, IEC and collection of reports from service sites. The IEC function is rapidly being taken on by any and all of the NGOs according to their target group or function. Collection of reports is moving to the MOHP, especially with the five regional MCH/FP supervisors recently in place. The function of distribution of contraceptives will continue as ATBEF has a contract with USAID and IPPF to import and distribute the contraceptives.

ATBEF has dedicated staff, long experience in certain areas but finally cannot begin to compete with the varied expertise available in the other partner agencies. Staffing at the regional level is very thin and barely permits the coordinator to distribute contraceptives. The coordinators are supposed to supervise the 31 motivatrices, give talks, liaise with officials, etc. It is of course very difficult to make any kind of a judgement at this time in Togo given two years of upheaval. However, the impression from the service providers was that contraceptive stockouts were a common thing even before the problems.

ATBEF as an IPPF affiliate is mandated to move into new areas where the government is not ready or willing to go. ATBEF will have to identify a unique role or niche for themselves here in Togo at this time since the activities that they were previously doing alone are now being done by the government (with assistance from many other technical agencies). IPPF or USAID may be able to assist ATBEF with this task. Some obvious roles for ATBEF are development and production IEC programs and materials, training for community workers in IEC and sale of contraceptives, reaching out to new or marginalized populations such as adolescents, males, adolescent males, teachers and professors, officials of ministries other than MOHP, etc.

In terms of the organizations concerned with HIV/AIDS, CARE has already been discussed and FAMME is another newly developed organization completely dependent on volunteers. FAMME will also need to be helped to learn the procedures and regulations required of a grantee. SOMARC will be able to call on Washington for its technical assistance.

5. Opportunities for reorientation, expansion and sustainability

Reorientation:

- * ATBEF to reorient some of its efforts to pursue innovative activities in FP which cannot yet be undertaken by the GOT; will need assistance with this task
- * ATBEF to choose one or two technicals area of FP in which to become expert to assist the

MOHP, other ministries and the NGO community

* CAs to make more of an effort to include private sector firms or institutions in their efforts in IEC, services, training, technical assistance (Mission hospitals, businesses)

* MOHP and CAs with USAID assistance to carefully review/renew the IEC production: target group, messages, media, point of impact, clarity of images/messages, number of copies, etc. An articulated strategy for reaching these groups to be developed and implemented

* All partners to review language used in the national program to determine if changes are useful. For example, review of different partners' understanding of "motivation", "promotion", "IEC" and "counseling". Discussion and clarification of terms and the activities that support them will be important for future activities especially with long-term and permanent methods

* CAs to pursue direct contact with each other to pursue lesson learned. For example, ATBEF to visit/study CARE work in the Plateaux using volunteers rather than salaried staff as the basis of community involvement and barrier method distribution

* MOHP to mobilize the field staff of other ministries to promote family planning and/or sell contraceptives (after proper training)

* Regional coordinators, supervisors and project managers to pursue coordination directly with each other to learn first hand and concretely what other activities are going on in the other regions and which are more or less successful

* MOHP and CAs to consider a morning-long in-depth exploration of a topic for the second day of coordination meetings rather than a schedule of discussing six topics for 15 minutes each

* INTRAH to start considering programming refresher training of those previously trained

* INTRAH to review the usefulness of pursuing the needs assessment at the prefecture level given the suspension by USAID of collaborative national activities

* MOHP to continue to decrease barriers to contraceptive supply and services and to recover some costs by sale of contraceptives

* CAs and MOHP to think of conducting small operations research studies when implementing new activities. Results to be shared with each other and with the international community

* CAs and ATBEF to assist newly started NGOs to conduct some activities for special target groups, i.e. prostitutes, students

* MOHP and CAs to revise reporting/recording system based and well-selected indicators and provide feedback to service sites

Expansion:

* MOHP and CAs to pursue expansion into Maritime and/or Kara. Expansion is possible in terms of addition of service sites, addition of new delivery systems (community based distribution of barrier methods), assistance with regional training.

* MOHP and CAs to decentralize training. The number of training sites (including practical training sites) to be rationalized given the need, projected demand, and unused capacity of existing training centers. Five training programs and 10-15 practical training sites may not be necessary for Togo.

* MOHP and CAs to study the experience of CARE as it moves into its new phase of reproductive health care in Plateaux and Savannes. The experience in the two regions may be different since Plateaux already has many operating service sites.

* MOPH, INTRAH and SEATS to pursue the addition of methods (NORPLANT, sterilization) to the methods currently available in Togo. Proper caution to be used in assuring technical expertise of providers and appropriate counseling services prior to patient's choice.

Sustainability:

* MOHP and CAs to charge for contraceptives to recover part of the cost

(It has been proposed that the service sites sell contraceptives received free, keep 33% and send 66% of the receipts to Lome. This will prove to be a difficult system as proceeds from other drugs sold will stay in the site. Instead of this, the MOHP might give one shipment of contraceptives free to sites to start out with. Then the service site sells the product for the appropriate cost: say 150 F for Noristerat. With the proceeds, they buy the second round of Noristerat for 100F. This results in the same percentage in the service site (50F or 33%) and in Lome (100F or 66%).

* MOHP to progressively cover more costs as time goes on: in addition to salaries covered now, the MOHP to cover local supervision costs, salaries of supervisors, cost of refresher training courses

**CHAPTER 4. RECOMMENDATIONS:
PROPOSED INTERVENTIONS AND MECHANISMS FOR USAID FUNDING**

The Phase II assessment team was requested by USAID to formulate recommendations in the form of short concept papers. These have been prepared for four interventions- development of health districts, reinforcement of health centers, drug supply system and family planning.

A. DEVELOPMENT OF HEALTH DISTRICTS

TITLE: Development of three pilot health districts: AFAGNAN, AGOU, DAPAONG

SECTOR: Health

Purpose/Rationale: to establish pilot health districts around functional NGO hospital/dispensary systems in order to improve access and utilization of PHC services and to test the effectiveness of a decentralized management system.

Specific Objectives:

- 1) Establish a geographically defined health district around an NGO hospital
- 2) Develop improved PHC services for each health area of the district
- 3) Increase utilization of health care services and essential medicines
- 4) Test the effectiveness of a decentralized management system
- 5) Establish a population-based HMIS system reporting to the MOHP
- 6) Increase sustainability through community financing of health services
- 7) Expand IEC and community development initiatives
- 8) Share lessons learned with other NGOs and the MOHP

Key Activities/Description:The four health districts would include:

Health District of:	<u>Afagnan</u>	<u>Agou</u>	<u>Pakala</u>	<u>Dapaong</u>	<u>TOTAL</u>
Region of Togo:	Maritime	Plateau	Central	Savanes	4 of 5 regions
Target Population:	60,000	100,000	50,000	100,000	360,000
Health Centers:	5	10	7	35	

Types of inputs required to develop a health district (HD):

- 1) Equipment, medicines & supplies for health centers(HC)/health posts(HP)
- 2) Minor Renovation of health centers; construction of a 1 or 2 new HCs
- 3) Supervision Vehicles: 4-wheel drive (HD), motos (HC), 48 bicycles (HP)
- 4) IEC equipment/materials for health centers and nursing school
- 5) Hospital/health district office equipment, e.g electric generator
- 6) Solar powered radio/lighting systems for health centers
- 7) Salaries for health center/health district personnel (local cost)
- 8) Supervision costs: fuel, maintenance, etc.
- 9) Training materials/sessions: health center and health post personnel
- 10) Technical assistance support for start-up, monitoring and evaluation

Funding Level and Mechanism: The estimated investment and operational costs for three years exclude personnel and depreciation which would be covered by NGO contribution, GOT support or cost recovery.

Health District of:	<u>Afagnan</u>	<u>Agou</u>	<u>Pakala</u>	<u>Dapaong</u>	<u>TOTAL</u>
Funding Level	\$300,000	\$600,000	\$400,000	\$1,100,000	\$2,400,000
Grant to:	CRS	PC(USA)	CRS	CARE	

Management/Oversight: This would depend on the grant mechanism used.

Direct Grants: Management and oversight of each health district would be the responsibility of the grantee. In each case this is a NGO with recognized management capability. Direct grants would preferably include a continued USAID presence in Togo to supply some project monitoring. However, this grant mechanism could continue without a USAID presence if sufficient TA (local or international) included for monitoring, auditing and evaluation.

Grants through a U.S. based PVO partner: This grant mechanism would place most of the management/oversight responsibility on a U.S. based PVO partner who is already experienced in dealing with USAID. These grants could be continued even in the absence of a USAID presence in Togo.

Comments:

AFAGNAN: The considerable population from Benin would be indirectly served by the health district of Afagnan. While Afagnan is the smallest in terms of population, it is the most advanced understanding and developing the health district concept.

AGOU: The EEPT (Evangelical Presbyterian Church of Togo) receives most of its support from Europe. However, it has established contacts with at least three U.S. based PVOs who might be interested in collaborating in this health district project. These groups are PC(USA): Presbyterian Church (USA), Disciples of Christ, and IMA: Interchurch Medical Assistance.

DAPAONG: The health district of Dapaong would be managed by the GOT medical chief with technical assistance/support from Iles de Paix. The health centers would include NGO management by Red Cross, Congat, OCDI, and Iles de Paix.

PAGALA: The health district of Pakala would require the placement of a medical doctor at the hospital. OCDI has indicated that this would not pose a major problem.

B. REINFORCEMENT OF HEALTH CENTERS

TITLE: Reinforcing NGO Managed Health Centers

SECTOR: Health

Purpose/Rationale: to reinforce the capacity of NGO managed health centers to improve access/utilization of PHC services and to develop population based planning/HMIS.

Specific Objectives:

- 1) Establish a geographically defined health areas for each NGO health facility
- 2) Develop improved PHC services for each health area
- 3) Increase utilization of health care services and essential medicines
- 4) Establish a population-based HMIS system reporting to the MOHP
- 5) Increase sustainability through community financing of health services
- 6) Expand IEC and community development initiatives
- 7) Share lessons learned with other NGOs and the MOHP
- 8) Reinforce the OCDI pharmaceutical distribution system

Key Activities/Description: A significant percentage of the Togolese population utilizes NGO managed health facilities. Only some of those facilities have active outreach activities into the surrounding communities, and fewer still are managing their activities with respect to a clearly defined health area. There are at least 70 known health centers, dispensaries, PMIs or health posts being managed by NGOs (see table below). Taking into account facilities managed by smaller NGOs and by community groups, it would be possible for this project to reinforce the activities of 100 NGO managed health centers, and improve PHC services for an estimated 500,000-700,000 people in all regions of Togo.

NGO	REGIONS					FOCUS	HC/disp	PMI/PS
OCDI	L	M	P	C	K	S	25 HC/disp	9 PMI/PS
"EET"	-	M	P	C	K	-	8 HC/disp	11 PS
Croix Rouge	L	M	P	C	K	S	16 disp	-
Nord-Sud				C			1 disp	-
							50 HC/disp	20 PMI/PS

Types of inputs required for 100 centers over 3 years:

- 1) Basic equipment, & supplies for health center/health post (\$400,000)
- 2) Matching grants for minor renovation of centers (\$300,000)
- 3) Supervision Vehicles: 1 4-wheel, 100 motos, 100 bicycles (\$350,000)
- 4) IEC equipment/materials for health centers (\$150,000)
- 5) Solar powered lighting systems 50 selected health centers (\$200,000)
- 6) Supervision costs: fuel, maintenance, etc. (\$200,000)
- 7) Training costs - health center/health post (\$200,000)
- 8) Annual NGO conference (\$200,000)
- 9) Renovation of OCDI national office, equipment, supplies (\$150,000)
- 10) Initial stocks of medicines for 100 centers (\$250,000)
- 11) Technical assistance to start-up, monitor and evaluate (\$100,000)

Funding Level and Mechanism: The estimated investment and operational costs for three years is \$2,500,000. This excludes personnel and depreciation which would be covered by NGO contribution, GOT support or cost recovery. A project grant could be made directly to OCDI with subgrants to other NGOs. The project could also be funded through a U.S. PVO, e.g. CRS.

Management/Oversight:

Direct Grant: Grantee and sub-grantees, e.g. EET and Red Cross, would be responsible for

management and oversight of health centers. A direct grant would preferably include a USAID presence in Togo to supply some project monitoring. However, this grant mechanism could continue without a USAID presence if sufficient TA (local or international) included for monitoring, auditing and evaluation.

Grant through a U.S. based PVO partner: This grant mechanism would place most of the management/oversight responsibility on a U.S. PVO partner experienced in dealing with USAID. This partner should have competence in commodity procurement, particularly for medical equipment and medicines. This grant mechanism could be continued even in the absence of a USAID presence in Togo.

Comments:(1) The table excludes 10 OCDI centers which would be assisted through the Dapaong health district project.

50% of the grant assistance, approximately \$1,250,000, would be provided in the form of commodities. Approximately 75% of the assistance "subgranted" by OCDI to EET and Red Cross would consist of commodities. Only about \$350,000 (14%) out of the total funding of \$2,500,000 would actually be managed by the subgrantees.

Glei hospital has requested operating room and transportation support (\$100,000) for its eyecare outreach program throughout the Plateau region. Tsiko hospital has requested \$100,000 to permit them to obtain \$300,000 additional funding from Germany to build a hydroelectric plant.

The following commodity lists are provided to illustrate the types of commodities which could be provided to health centers. Prices are from an out-of-date UNIPAC catalog. Current prices based on U.S. procurement might double the listed cost, i.e. \$4000/CS.

KIT A: HEALTH CENTER EQUIPMENT	NUMBER	#ITEMS	COST
=====	=====	==	=====
MCH-A-CENTRE BASIC EQUIPMENT	9902401	68	\$429
MIDWIFERY-KIT TYPE 3	9902101	39	\$70
SYRINGE KIT C	9907200	9	\$133
MICROSCOPE BINOCULAR	957104	1	\$440
ASSORTED LAB EQUIPMENT		30	\$268
REFRIGERATOR 220V/KEROSENE	1121480	1	\$563
SPARES CHIMNEYS & WICKS		6	\$40
REFRIGERATOR REPAIR KIT	1152000	9	\$23
VACCINE CARRIER + ICE PACKS	1185000	1	\$34
		Total	\$2,000

KIT B: HEALTH CENTER EQUIPMENT	NUMBER	#ITEMS	COST
=====	=====	==	=====
SELECTED ITEMS: MCH-A-CENTRE	9902401	30	\$200
MIDWIFERY-KIT TYPE 3	9902101	39	\$70
SYRINGE KIT C	9907200	9	\$133
SPARES CHIMNEYS & WICKS		6	\$40
REFRIGERATOR REPAIR KIT	1152000	9	\$23
VACCINE CARRIER + ICE PACKS	1185000	1	\$34
		Total	\$500

REFERENCE LIBRARY FOR HEALTH CENTER	COST
=====	=====
LA OU IL N'Y A PAS DE DOCTEUR	\$15
COMMENT BATIR LA SANTE	\$20
LA CONSULTATION DE CONTRACEPTION EN AFRIQUE	\$15
HELPING HEALTH WORKERS LEARN	\$15
MATERNITE ET SANTE	\$15
L'ENFANT ET SANTE	\$15
FLANNOGRAPH CPS	\$15
INFIRMER COMMENT TRAITER VOTRE MALADE	\$15
"IPPF" FAMILY PLANNING FLIPCHART	\$15
COMMENT BATIR LA VIE	\$15
ASSORTED FLIPCHARTS, ETC	\$45
	Total \$200

C. DRUG SUPPLY SYSTEM

TITLE: Reinforcement of NGO Drug Supply and Cost Recovery Systems

SECTOR: Health Services Delivery

Purpose/Rationale: To improve the effectiveness of NGO drug supply and cost recovery systems in order to ensure the availability of low cost generic drugs in NGO managed health facilities on a sustainable basis.

Specific Objectives:

- 1) Larger, more functional drug warehouse facilities in Lomé.
- 2) New intermediate drug depot in Sokodé.
- 3) New regional pharmacy in Dapaong (combined with pilot health district).
- 4) More reliable drug supply through more effective procurement, distribution and inventory control.
- 5) Greater cost recovery through better financial management procedures.
- 6) Increased sustainability through improved institutional capability.

Key Activities/Description: The project would improve drug distribution to and cost recovery in 50 health centers/dispensaries and 20 PMI/health posts providing services to 350,000 inhabitants living throughout Togo.

Types of inputs required for the drug supply and cost recovery systems over three years:

Improve infrastructure of drug supply system.

*Expand OCDI warehouse, Lomé:	\$50,000
*Set up OCDI depot, Sokodé:	\$25,000
*Set up pharmacy, Dapaong (health district):	\$25,000
*Provide equipment and vehicles:	\$100,000
Total	\$200,000

Supply initial drug stocks for depots: \$350,000

Personnel: 4 FTE staff at Lomé, Sokodé and Dapaong
Year 1: 100%; Year 2: 50%; Year 3: 0% \$150,000

Technical assistance and training:

*Provide CRS based technical advisor to assist with system design and initial operations, to train key staff and develop internal TA capability. (2 years @ \$100,000/yr)	\$200,000
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Funding Level and Mechanism:

Total estimated direct cost.(excludes local match) \$900,000

Direct grant to OCDI or grant through CRS

Management/Oversight: This would depend on the grant mechanism used.

Direct Grants: Management and oversight of each health district would be the responsibility of the grantee. In each case this is a NGO with recognized management capability. Direct grants would preferably include a continued USAID presence in Togo to supply some project monitoring. However, this grant mechanism could continue without a USAID presence if sufficient TA (local or international) included for monitoring, auditing and evaluation.

Grants through a U.S. based PVO partner: This grant mechanism would place most of the management/oversight responsibility on a U.S. based PVO partner who is already experienced in dealing with USAID. Indirect grants could be continued even in the absence of a USAID presence in Togo.

D. FAMILY PLANNING

TITLE:Improving accessibility and quality of family planning services

SECTOR: Health

Purpose/Rationale: to increase number of sites where services are available, to make all modern temporary methods available at these sites and to improve the quality of services for all methods. Activities performed toward these aims will result in more acceptors of modern methods who continue to use their method for a longer period of time.

Specific Objectives:

- 1) Establish services in underserved areas in three regions (Plateaux, Centrale and Savannes)
- 2) Develop improved quality of services at sites
- 3) Improve community understanding and acceptance of FP
- 4) Transfer technical expertise of CAs to MOHP and NGOs
- 5) Identify areas for collaboration with UNFPA-funded regions (Maritime, Kara)
- 6) Improve contraceptive supply lines and distribution
- 7) Improve recording/reporting systems and feedback to sites

Key Activities/Description:The services to be available:

Region:	Plateaux	Centrale	Savannes
Major CAs:	CARE, SEATS	SEATS	CARE,SEATS
Population:	823,000	345,000	421,000

Types of inputs required to expand and improve services:

- 1) Medical equipment, supplies and contraceptives
- 2) Renovation
- 3) Supervision vehicles (may not be required)
- 4) Funds to design, develop, pre-test, produce IEC
- 5) Funds for initial and refresher training courses
- 6) Funds for operations research
- 7) Funds for travel (supervision, coordination)
- 8) Funds for technical assistance for above if required
- 9) Funds for salaries (on an exceptional basis)

Funding Level and Mechanism: The estimated cost would be about \$900,000 to \$1,000,000 per year for the CAs based on their current one year budgets and allowing \$250,000 per year for a grant to ATBEF through IPPF. This estimate excludes the cost of contraceptives which will come from a separate budget. Since there will be no Mission presence, a coordinator (from IPPF or AID/W) will be required to oversee and manage USAID/Togo's entire FP program. More visits from the US staff of the CAs will most likely be programmed than have been taking place to date and the CAs may request more help with overhead and salary costs.

Management/Oversight:The management mechanism will be a buy-in to each of the CAs and a buy-in to IPPF for ATBEFF to carry out the planned activities. The CAs can manage and supervise their

own activities in conjunction with USAID if the Mission remains in Togo. If there is no USAID presence, the parent agencies at the headquarters' offices will be able to perform the added oversight functions if necessary. This of course will be more expensive. Also AID/W or REDSO could send a person out once a year to have a look at what is really happening on the ground.

Comments:

1. Small grants for one-time activities for new NGOs could be made the responsibility of ATBEF. These would be no more than \$3000-4000 for a conference, production of worthy IEC materials, etc. It is not a travel slush fund but an opportunity to respond to the many requests for small sums of money to carry out a small but innovative activity.
2. If SEATS ceases to exist after September 1994, another mechanism will be required for the identification and equipping of service sites and other costs born by them currently.

SUMMARY OF HEALTH & FAMILY PLANNING INTERVENTIONS PROPOSED WITH NGOS

PROJECT/ ACTIVITY	PURPOSE/ RATIONALE	OBJECTIVES
Develop pilot health districts	Establish pilot health districts around functional NGO hospitals to improve access and utilization of PHC services and to test the effectiveness of a decentralized management system.	<ol style="list-style-type: none"> 1) Establish a health district around an NGO hospital 2) Develop improved PHC services in each health area 3) Increase utilization of health care services 4) Test the decentralized management system 5) Establish a population-based HMIS system 6) Increase sustainability through community financing 7) Expand IEC and community development initiatives 8) Share lessons learned with NGOs and the MOHP
Reinforce NGO Managed Health Centers	Reinforce the capacity of NGO managed health centers to improve access/utilization of PHC services and to develop population based planning/HMIS.	<ol style="list-style-type: none"> 1) Establish health areas for each NGO health facility 2) Develop improved PHC services in each health area 3) Increase utilization of health care services 4) Establish a population-based HMIS system 5) Increase sustainability through community financing 6) Expand IEC and community development initiatives 7) Share lessons learned with NGOs and the MOHP 8) Reinforce the OCDI drug supply distribution system
Reinforce NGO Drug Supply and Cost Recovery Systems	Improve the NGO drug supply and cost recovery systems in order to ensure the availability of low cost generic drugs in NGO managed health facilities on a sustainable basis.	<ol style="list-style-type: none"> 1) Enlarge OCDI Lome drug warehouse facilities 2) Establish intermediate drug depot in Sokodé. 3) Establish new regional pharmacy in Dapaong 4) Increase procurement, distrib. & inventory control 5) Improve cost recovery & financial management 6) Increase sustainability & improved NGO capability.
Improve accessibility and quality of family planning services	Increase Family Planning services availability for modern temporary methods and improve service quality for all methods.	<ol style="list-style-type: none"> 1) Establish services in 3 underserved regions 2) Develop improved quality of services at sites 3) Improve community understanding/acceptance of FP 4) Transfer technical expertise to MOHP and NGOs 5) Identify areas for collaboration with UNFPA 6) Improve contraceptive supply lines and distribution 7) Improve recording/reporting and feedback systems

E. RURAL HEALTH PROJECT MODE AND FUNDING MECHANISM

It is recommended that the four proposed interventions be funded as two projects

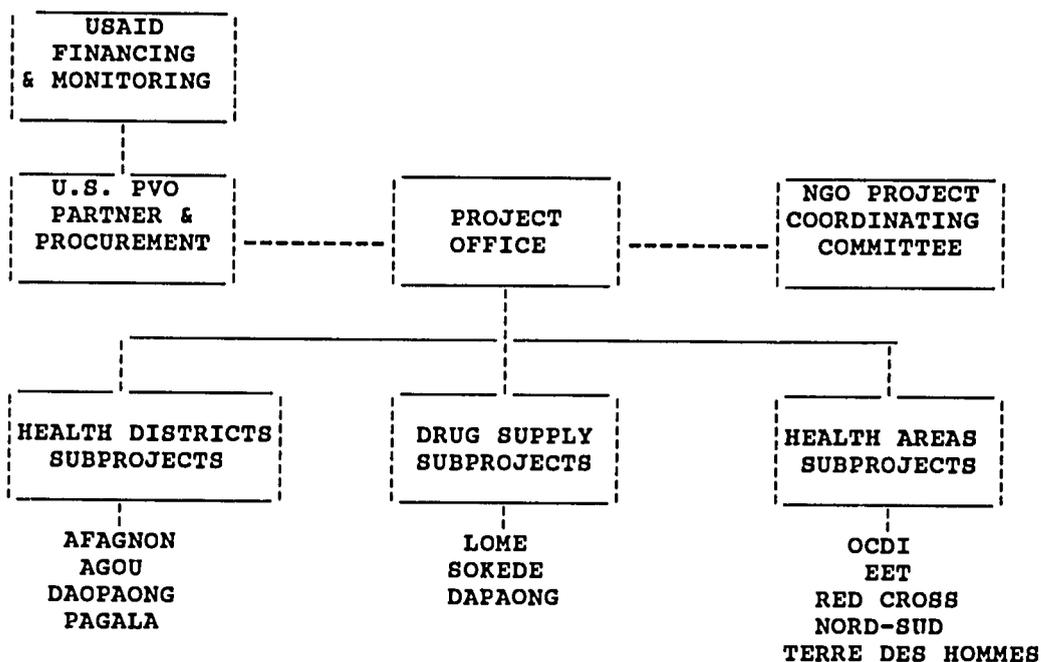
- 1) family planning interventions through buy-ins (as described above)
- 2) a rural health project combining interventions 1, 2, and 3 funded through a U.S. PVO, which is known and trusted by the NGOs who would be participating in the project.

Project management would be the responsibility of a project office established in Lome, probably at OCDI or EET headquarters. Preliminary discussions with OCDI and EET indicate a sincere willingness to collaborate in joint management of one umbrella project.

An NGO coordinating committee would be established with representation by the various NGOs involved in the project. Given the fact that most of the project assistance would be to health facilities of linked to OCDI or EET, these two NGOs would be given the greatest role in project management. For example, the medical director of OCDI might be the project director and serve as the secretary of the NGO coordinating committee while the EET medical director would be the president of the NGO coordinating committee.

Given the good management capacity of OCDI and EET, and in order to encourage the development of this national NGOs, it is recommended that the role of the U.S. PVO should be grant management, and financial disbursements and procurement of commodities. The U.S. PVO would identify and hire appropriate technical assistance to work within not the project structure, reporting to the project director rather than directly to the PVO.

Figure 2
PROPOSED FUNDING MECHANISM FOR THE RURAL HEALTH PROJECT



Annex A: List of Documents Reviewed

Analyse de la Politique de Recouvrement des Coûts, MCDI, Jun 92.
Annuaire des Statistiques Sanitaires, Dir Planification, Formation & Recherche,
Health and Population Sector Support, USAID/Togo, Aug 1992.
List of 25 NGOs Approved by UNDP, Apr 93.
Liste des Unites de Soins Au Togo, MOH, Sep 93.
NGO Inventory Phase I - Health and Population Sector, Samuela Adeen Bell, USAID/
Program Portfolio Review & PIRs, USAID, Jun 93.
Projet de Survie de l'Enfant et Population, ATBEF,
Rapport Annuel de Ile de Paix-Dapaong (1991), Iles de Paix (Vredeseilanden), Jan
Rapport de Mission, Ahawa, A.K.M., Croix-Rouge Togolaise, Jul 1993.
Rapport de Session des Agents de Sante de l'Eglise Catholique du Togo, OCDI, 198
Repertoire des ONG au Togo, FONGTO, Mar 1992.
Togo Child Survival Project (TCSP), USAID, Sep 91.
USAID Togo Health Sector Analysis, Bossert, et al, URC, Jun 90.
USAID/Togo Country Program Strategy 1993-1998, USAID/Togo, Nov 92.

Documents Consulted for Family Planning

Programme de travail et budget 1993, Association Togolaise pour le bien-etre familial (ATBEF), 1992

Plan Triennial 1994-1996, ATBEF, 1993

Rapport du Seminaire Atelier d'education des eleves et etudiants en matiere de planning familial et les maladies sexuellement transmissibles, Comite d'action pour la cooperation internationale et l'epanouissement de la jeunesse (CACIEJ)

Constitution, CACIEJ

Ce qu'est L'ATBEF, ATBEF

A La Decouverte de Notre Corps, ATBEF, 1992

Rapport Annuel d'activites 1992, Forces en Action Pour le mieux-etre de la mere et de l'enfant (FAMME), 1992

Lutte Contre le SIDA et amelioration des conditions de vie des jeunes femmes marginalisees, FAMME, 1993

Carte de couverture de services de planification familiale au Togo, Noelie Hounzah, 6 August 1993

USAID Togo Health Sector Analysis, Thomas Bossert et al, June 1990

USAID/Togo program Portfolio Review and Project Implementation Reports, Office of the AID Representative, June 1993

Project de survie de l'enfant et population, ATBEF, April 1993

Scope of Work: Buy-in between the office of the AID representative to Togo and CARE International, CARE, 1993

Private Sector Family Planning Initiatives in Togo: Buy-in to Pathfinder project, Pathfinder, 1993

Scope of work: Buy-in to SEATS project, SEATS, 1993

Enquete Demographique et de la sante au Togo 1988, Unite de Recherche Demographique, Direction de la statistique, Direction Generale de la sante et Demographic and Health Surveys, Institute for Resource Development/Macro Systems, Inc., 1988

Annex B: Profiles of NGOs

OCDI: ORGANISATION DE LA CHARITE POUR LE DEVELOPPEMENT INTEGRE

A. General.

The "Organisation de la Charité Pour le Développement Intégré (OCDI)" is the major coordinating body for all of the Catholic health care facilities in Togo. Founded in 1987, it has as its overall objectives the stimulation of an active Christian role in social assistance; the extension of charity in unjust situations and in cases of suffering, hunger and underdevelopment; the organization of charitable services; and the coordination of the socio-economic efforts of diocesan institutions.

The organizational structure extends from the parish to the diocese and ultimately to the national level. Governance is achieved through a national board which includes diocesan representatives, while regional coordination is achieved through diocesan committees.

The activities of OCDI are grouped into three major service areas; emergency humanitarian assistance; community motivation (animation) and training; and human services and development. Projects include a broad range of activities in the areas of agriculture, animal husbandry, water, support to artisans, development of small enterprises, education and health services.

The major roles played by the national OCDI office are the operation of the drug distribution system and the planning and coordination of church supported health services in the four dioceses. This coordination is achieved through an annual meeting held each November, attended by representatives of each Catholic health facility, as well as by representatives of the MOH. This meeting is used to address issues of common interest and to formulate general plans for the next year.

OCDI has an official working relationship with the Ministry of Health and the Ministry of Social Welfare. OCDI facilities work with local and regional MOH personnel in their respective areas. Some of the OCDI facilities are staffed with MOH personnel. In some instances there is close collaboration between MOH and OCDI facilities, as is the case with the hospitals in Dapaong.

B. Staffing and Funding.

The national OCDI office has a staff of 12 employees of whom 4 are involved in the health program: the national coordinator for human services and development, the national medical director, a volunteer physician and a program assistant.

The 1992 budget was about 72 million FCFA. These funds were earmarked for program operation (personnel, equipment, drugs and transportation) and for project funding based on requests submitted by individual health facilities for construction, renovation, equipment, etc. Each facility gets a portion of the funds needed for specific projects from its congregation and/or the community. OCDI covers what it can and seeks external funding for the balance. CRS, CARITAS and CIDSE are major donors.

C. Programs.

1. Drug Distribution. As mentioned above, the operation of the drug procurement and distribution system is one of OCDI's most important activities. Drugs are purchased from IDA using funds contributed by the Catholic Medical Mission Board, other donations, or obtained through sales and are then sold to member health facilities at a slight mark-up to cover shipping costs and the operation of the depot. Problems cited by Dr. Tagore, who is responsible for drug distribution, and by the centers which depend on OCDI for supplies are occasional stock outages, and delays in drug procurement and distribution. This issue is discussed in greater detail in the section on drug supply and cost recovery.

2. Coordination and Clinical Supervision. The governing body of OCDI formulates triennial nationwide strategic plans for the organization and specific annual plans for OCDI national staff. Program coordination is achieved through an annual meeting of all members held each November and through quarterly meetings with health facility representatives held in each diocese. Within each diocese there is a nurse designated as clinical coordinator, but this individual is usually occupied on a full time basis in providing clinical services and therefore has little time to devote to the coordination function.

Two physicians on the OCDI national staff attempt to visit the facilities on a regular basis to provide clinical supervision and to improve the quality of health services, but resources are currently inadequate to provide the level of oversight desired.

3. Health Services Delivery. OCDI functions as an association of autonomous health facilities and not as a coherent health services delivery system. Membership includes 49 Catholic facilities located throughout the four dioceses in Togo. In

addition, a number of E.E.T. health facilities hold what might be called associate membership in OCDI.

The facilities affiliated with OCDI include hospitals, health centers and MCH (PMI) centers, which provide a broad range of preventive and curative services. Specific services provided by each facility visited during the first phase of this study are listed in a separate section of the NGO inventory.

Preventive services are provided by all facilities, especially the MCH centers, and through extension work at the village level. These services include vaccination, diarrheal disease control, deworming, malaria prevention and environmental sanitation. Most of the facilities provide growth monitoring and nutrition counselling. The nutritional rehabilitation centers (CREN) provide training on good weaning practices and nutrition, as well as rehabilitative services.

In Catholic facilities, family planning services are limited to natural family planning counselling. Both Dr. Tagore and his assistant, Sr. Akakpo, are trained in AIDS education and are attempting to provide facilities with materials, information and training on AIDS.

4. Health Information. Most facilities submit monthly reports on health statistics and services directly to the regional medical director. Additionally, each facility sends an annual report to OCDI, which in turn reports to its donors.

In general, facilities do not make effective use of population-based data for program planning and management. Few utilize data compiled for monthly MOH reports for internal management even though simple analyses of this information could yield valuable insight into the operation of their centers and the effectiveness of their activities. The MOH does not routinely use reported data as a tool in supervising these facilities nor does it provide feedback to the health facilities based on an analysis of reported data. However, some hospitals do produce internal reports of utilization, costs and revenues as a management tool.

5. Cost Recovery. OCDI facilities have been engaged in some form of cost recovery throughout their existence. However, it is mostly in recent years, when confronted by rising costs and increased difficulty in raising sufficient funds through contributions, that these charitable institutions have realized the need to generate revenues through patient fees.

As is described in greater detail elsewhere in this document, there are significant differences in cost recovery among OCDI and EET facilities. Hospitals, with their higher costs and more sophisticated management systems, have more formalized billing and collections procedures. For example, AFAGNAN relies on patient revenues to cover about 30% of its total operating costs, while BETHESDA indicated that its collections finance nearly 70% of its operating expenditures.

Among health centers, attitudes regarding charging patients for services vary considerably, as do billing practices. Some facilities have separate charges for drugs, consultations and procedures while others charge a flat fees for all services or simply request a contribution from those deemed capable of paying. However, staff in many of the facilities visited during the first phase of this study reflected an interest in improving their cost recovery procedures.

D. Organizational Capability.

It is evident that OCDI staff at all levels are dedicated to their work and highly motivated. However, in many respects the organization is over-extended, resulting in inconsistent performance. A common complaint among members is the unreliability of the drug supply system. Larger facilities, such as AFAGNAN and BETHESDA, have chosen to import drugs themselves rather than rely on OCDI. Inadequate resources have also limited the health services delivery capability of OCDI facilities.

There is a general consensus, both within and outside the organization, on the existence of these problems and on the actions necessary to resolve them. The major obstacle is the lack of resources. There is a need for more adequate warehouse facilities, especially if the role of the depot is to be expanded.

The depot currently shares a truck with all of the other sectors within OCDI. Another truck would greatly facilitate drug distribution. The depot is also understaffed; additional personnel are needed if the system is to function effectively. There is also a need to increase inventory levels to ensure adequate minimum stock levels to reduce the probability of outages.

However, increasing resources will only solve part of the problem. There is also a need to improve management procedures relating to projecting drug consumption, procurement practices, inventory control, financial management and budgeting. More effective operation of the depot in Lomé also depends on improved management practices at both the diocesan and facility levels.

In summary, OCDI is an effective and credible NGO playing an important role in health services delivery in Togo. Moreover, the organization is willing and able to expand this role. The problems which OCDI is currently experiencing are attributable in large part to inadequate resources and could be resolved through the type of financial and technical assistance available through USAID.

E. The "Hopital Saint Jean de Dieu d'Afagnan"

Since its establishment in 1964, the "Hopital Saint Jean de Dieu d'Afagnan" has expanded from its original 80 beds into a 250 bed facility providing an extensive range of preventive, curative and rehabilitative services. Major services include OB-GYN, Pediatrics and Orthopedic Surgery. The hospital also serves as a referral center for the treatment and rehabilitation of polio victims, providing corrective surgery, physiotherapy and fitting patients with prosthetic devices.

During 1992 the hospital functioned at theoretical capacity, providing 91,000 patient days of hospitalization, performed over 3000 surgical operations two-thirds of which were classified as major procedures, and treated 8000 new ambulatory cases. The hospital obtains its drugs directly from overseas sources and from the Centrale d'Achat in Cotonou, Benin.

Also located on the hospital campus is the Centre de Santé Saint Jean de Dieu d'Afagnan, which serves as a dispensary providing primary care to the Afagnan population.

The facility has a staff of approximately 125, including five Togolese physicians. The hospital director is a dynamic religious brother and surgeon, Dr. Fiorenzo Priuli, also known as Frere Florant. The staff includes several brothers of the Saint Jean de Dieu congregation and nurses who are members of the Notre Dame de l'Eglise congregation.

The hospital charges inpatients who can pay an all-inclusive fee of 1000 FCFA per day, which covers about 25% of the facility's operating costs. Outpatient fees increase total collections to 30% of operating costs. The hospital therefore relies heavily upon external sources, mainly Italian, for its support. It is currently seeking funds for a major renovation of its physical plant and for a community-based primary health care program.

The AFAGNAN hospital operates one of two nursing schools in Togo using a curriculum based upon one designed by the MOH. There are 15 students currently enrolled in the program. While only religious personnel have been admitted to the school in the past, discussions are underway with the MOH regarding the possibility of opening enrollment to laypersons.

In addition to its role as a referral center, the institution has a strong community orientation and is involved in twenty-eight villages located throughout the Afagnan sub-prefecture, which has a population of 90,000. The hospital director is working with three operational public sector health centers and is exploring the feasibility of setting up two additional centers in order to provide full coverage in this "health district." Plans also include setting up a cost recovery program to ensure to continued availability of low cost generic drugs.

The hospital is a progressive organization and its director is well qualified to develop and manage the proposed health system for the Afagnan sub-prefecture. He apparently has a good working relationship with the MOH, which he indicated was willing to participate in the proposed joint venture.

Frere Florant is thoroughly familiar with the operation of other OCDI facilities and indicated that he visited a number of these on a regular basis to provide specialized medical services. He was also aware of the relative strengths and weaknesses of the OCDI drug distribution system.

The proposed "health district" demonstration project appears consistent with general USAID strategies and objectives and should therefore be considered for funding through CRS/OCDI.

CATHOLIC RELIEF SERVICES (CRS)

A. General.

Catholic Relief Services is a U.S. based NGO which has been involved in numerous Third World countries for several years. It has been active in Togo since 1943. Its major thrust has been strengthening the institutional capability of local counterparts in the areas of small enterprise development, agriculture, nutrition and public health. The prime beneficiaries of these activities have been women, and children.

B. Funding and Staffing.

CRS-Togo employs a staff of forty Togolese and two expatriates. Of these, five work in the food and nutrition programs and one is involved in community health. The annual budget includes \$4 million for maternal and child health, school feeding and humanitarian assistance. The public and community health budget is \$100,000 per year. Major sources of funding are the U.S. Government through the "Title II" program and Catholic Relief Services. CRS does engage in a form of cost recovery. Foodstuffs are "monetized", i.e., sold to SGMAT in order to generate funds for the operation of its food warehouse and MCH centers and for the distribution of these supplies.

C. Program Activities.

1. Nutrition. Until mid-November 1992, CRS was engaged in two small enterprise development projects in the Central and Plateau Regions. These involved training artisans in different trades in improved techniques and in basic business skills. The projects also have provisions for start-up loans through a revolving fund. In the Savanes Region, CRS also funded an agricultural project focusing primarily on farmer training.

Additionally, CRS operated a nationwide nutrition program in 91 MCH centers, which included growth monitoring and food distribution under Title II. Center staff were paid by the GOT and some operating funds were generated through "contributions" of 100 FCFA per visit. There were also 73 institutions participating in the CRS school feeding program. On 16 November 1992, CRS suspended program activities because of the strike and for reasons of security. However, last January CRS initiated an emergency food distribution program aimed at helping those most seriously affected by the results of the strike. Singled out for assistance were the elderly, the handicapped and single women with three or more children.

In conjunction with the "Organisation de la Charité pour un Développement Intégré (OCDI)", the program distributed 700 tons of food in the Lomé area and an additional 2500 tons of food throughout the country. While problems were encountered during the initial phases of the program, on the whole, the program was successful in meeting its objectives.

2. Preventive Health. In addition to the extensive nutrition program outlined above, CRS is also providing support to GRAD/Bé, a local NGO working in the Bé section of Lomé. The project, which is not tied to the health care delivery system, includes community outreach, as well as education in nutrition and hygiene. A similar project involving four OCDI health centers serving a total of 60 villages has been planned for SE Maritime Region.

3. Assistance to Health Facilities. While not directly involved in the delivery of primary health care, CRS does provide support to over fifty facilities through the national office of OCDI. During 1993, CRS received \$350,000 from the Catholic Medical Mission Board (CMMB), which was used to purchase pharmaceuticals for OCDI health facilities through IDA.

D. Organizational Capability.

Through its implementation of the Title II program in Togo over the last several years, CRS has demonstrated its organizational capability in program planning and management, in financial management and in maintaining liaison with USAID and various ministries of the GOT.

CRS representatives have expressed a willingness to play an active role in helping OCDI carry out a USAID funded expansion and strengthening of its drug distribution activities. This support could include direct assistance in drug procurement and financial management, as well as training and technical assistance in the operation of drug distribution systems and in financial management.

CARE INTERNATIONAL

A. General.

CARE has been in Togo since 1987 working in health and agroforestry. The family planning activities started in 1991 when CARE/USA received a central cooperative agreement from AID/W. AIDS activities began in 1990 with contributions from CARE France, the World Bank and FAC. The AIDS office is in Lome and the family planning office is in Plateaux. Another family planning project is starting October 1993 in Savanes and Plateaux and an AIDS continuation project will begin January 1994 in the whole country.

B. Staffing and Funding.

CARE has a staff of 20 persons, about half professionals and half support staff. There are also 150 volunteers in Plateaux and more will be added with the new family planning and AIDS projects described above. Funding comes from the offices of CARE International affiliates, and from multi-lateral and bilateral donors. There is an office in Lome and regional offices in Atakpame for family planning and Kara for agroforestry project. The activities of the family planning project are centrally funded to date with a \$375,000 budget for the current fiscal year. The HIV/AIDS project's budget is about \$125,00 for 18 months.

C. Program Activities.

1. Family Planning: The purpose of the project is to increase the contraceptive prevalence to 16% among women of reproductive age by the end of the project in April 1996 and to increase the knowledge of modern methods of contraceptives. The project works in MOHP dispensaries in the Plateaux region using government staff and volunteers to educate and serve the people. In the dispensaries the staff were trained in hormonal methods of FP and later brought back for IUD training. All training was conducted in Plateaux using INTRAH-trained trainers. The volunteers are trained to educate and sell barrier methods. After two years of activity, the project has already trained all the personnel projected for the five year period, and activated all the dispensaries projected for the five year period.

Another project involving reproductive health care will be starting in late 1993 in Plateaux and Savanes. New interventions to be covered are pre- and post-natal care and deliveries, as well as treatment of STDs. FP activities will begin in the Savanes also. The projected increase in prevalence in the Savanes will be from 0 to 3%.

2. HIV/AIDS: The purpose of the project is to use drivers at busy Lome terminals to educate people about HIV/AIDS and sell condoms. The project runs from April 1992 to December 1993 and has trained 90 drivers as of mid-1993. A follow-on project for January 1994 will extend the activities to the whole country with 360 drivers to be trained. Also another target group will be added as the project attempts to reach prostitutes and students in schools around the terminals.

D. Organizational Capability.

CARE is well equipped to plan and manage its current and planned projects based on the evidence of the accomplishments. CARE has attracted several donors for its projects and plans to continue these efforts. A broad role for this agency in Togo will be useful to the health sector and to its beneficiaries.

PROTESTANT CHURCHES OF TOGO ("EET")

A. General

In 1978 the government of Togo limited the number of protestant mission groups. At this time there are five protestant churches actively working in the health field and are collectively referred to as the "EET" (Eglises Evangelique du Togo). This is often confused with the EET, the Evangelical (Presbyterian) Church of Togo. There is little coordination between the five NGOs, though there is a meeting scheduled to propose a more organized association of protestant churches.

B. Staffing, Funding and Programs

1) SDA: Seventh Day Adventists manages the ophthalmological hospital of Glei. The hospital staff includes two missionary doctors, one who is a pediatrician and who does do limited general practice. Their primary interest at this time is to reinforce and sustain the eye program in order to serve as a regional reference center, including a mobile eye service. They would like to upgrade the hospital facilities (new OR and X-ray) to permit a full spectrum of general services.

2) ABW: Association of Baptists for World Evangelization began work in the Kpalimé area in 1974. They developed a center for the blind a Kpalimé and have a hospital at Tsiko. The medical staff includes two general surgeons, four national nurses, five missionary nurses, and two family practice missionary doctors. There are no Togolese doctors currently working at Tsiko. They currently have no community outreach program. Their programming priority has been to sustain and expand the work of the hospital. Given the availability of resources, they may be interested in re-attempting a community outreach program, but could not, at the point, be considered a strong candidate for developing a health district.

3) SMB: Southern Baptist Mission manages a health center of Morétan, north of Elavagnon (Pleateaux) and has one missionary doctor on staff. The assessment team was not able to visit this center, however, it is probably a good candidate to establish a health area program.

4) AG: Assemblies of God work throughout Togo and, as of 1990, had 18 missionaries in Togo. One of the churches in the Plateaux region is currently building a health center at Kane near Notse which they estimate will serve approximately 12,000 persons and should open in mid-december 1993. AG works with a village health committee in Kane to plan the services and organization of the health center. The community has contributed almost \$7,000 themselves towards the cost of the center. AG also receives funding from the U.S. National Assemblies of God church and the Assemblies of God Health Services department (U.S., as well as from private donations. A missionary nurse, Audrey Ross, works with the AG health program, and holds 3 day seminars through sponsoring churches on general health topics. She usually covers topics such as AIDS, Family Planning (sex education), disease prevention, hygiene, and nutrition. The assessment team was not able to visit this center, however, it may be a candidate to establish a health area program.

5) EET: Evangelical (Presbyterian) Church of Togo manages the Agou hospital and a dispensary network that includes 3 health centers, 4 dispensaries and 11 health posts. The medical staff includes five Togolese (no missionary) doctors. Funding is primarily by cost recovery (70% of expenses) with some assistance received primarily from the German Bremen Mission and a German aid agency EZE (Evangelische Zentrastelle fur Entwicklung). The EET has contacts, but currently no assistance, in the U.S. with the Presbyterian Church(USA), the Disciples of Christ, and the Interchurch Medical Association (IMA).

The Agou hospital is located in the newly created prefecture of Agou. There is currently no governmental reference hospital for this prefecture. Agou would be a good candidate to become the reference hospital and central office for the health district of Agou which would encompass a population of 100,000 and ten government dispensaries.

Annex C: HIS, COST RECOVERY, AND DRUG SUPPLY

DRUG SUPPLY AND COST RECOVERY

Drug Distribution and Health Care Financing in the Public Sector.

The evolution of health care financing and cost recovery in Togo, especially as it relates to the public sector, is described in several documents, e.g., the TOGO HEALTH SECTOR ANALYSIS, the Togo Child Survival and Population (TCSP) project paper and the Health and Population Sector Support (HAPSS) non-project assistance program document. For this reason, this section presents only a brief examination of drug procurement and health care financing in the public sector as background for the discussion of drug supply and cost recovery systems in private health care programs operated or supported by non-governmental organizations (NGO's).

1. Current Public Health Services Funding.

Since independence, Togo has adhered to the philosophy that health care is a human right and that health services should be available to the population free of charge. Unfortunately, Togo is one of the poorest countries in the world and the harsh economic constraints under which it operates, compounded by gross inefficiencies in health services delivery, have prevented the country from translating this philosophy into reality for the majority of its citizens.

Health expenditure patterns in Togo closely resemble those observed in other Third World countries. Togo currently devotes about 5% of its public expenditure budget to recurrent health costs. While financial data are extremely limited, available sources indicate that the country allocates an inordinate share of its budget to hospital services at the expense of primary health care. The country remains heavily dependent upon international donors for investments in health infrastructure.

Because of pressures placed on the country to reduce public sector expenditures, in part as a result of the structural adjustment program, MOH per capita health expenditures, expressed in real terms, have declined steadily in recent years. Despite plans to reduce personnel costs, these now consume nearly 80% of the MOH recurrent cost budget. There has consequently been a continuous decrease in funds available to cover non-personnel costs, including drug purchases.

2. The Public Sector Drug Supply System.

Until recently the decreasing real per capita funding available for drug purchases has been exacerbated by the fact that the MOH was required to procure drugs through TOGOPharma, the sole authorized importer, which limited its inventory to high cost proprietary pharmaceuticals obtained primarily from France. TOGOPharma was also the only supply source for private retail pharmacies in Togo.

This monopoly was broken by presidential decree in August, 1991, thereby permitting the MOH to obtain lower cost generic drugs on the open market. The MOH plans to improve the availability of drugs through the establishment of a system which would include a national pharmacy, PharmaPro and a network of regional and prefectural depots. However, there has been little progress in the development of an alternative supply system.

Because drug supplies available in MOH health facilities remain inadequate, patients are frequently given prescriptions and referred to the private pharmacies. Those unable to pay often obtain less medication than the amount prescribed, purchase unauthorized drugs through the informal market or do not obtain any drugs at all.

3. The Introduction of Cost Recovery in MOH Facilities.

Faced with inadequate funding and uncertain prospects for an increase in budgetary allocation, the MOH has authorized a number of cost recovery initiatives as a way to increase resources available for health services delivery. UNICEF, GTZ and FAC have been involved in demonstration projects in which low cost essential drugs are sold through village pharmacies, with the proceeds utilized not only to replenish drug stocks, but also to cover at least a portion of health center operating costs.

UNICEF is implementing the Bamako Initiative in Togo through the establishment or strengthening of community-based pharmacies which carry an inventory of 30 essential drugs and which are governed by Village Development Committees (CVD'S). This assistance includes the provision of training and technical assistance to prefectural MOH staff and CVD members. By 1994, the project plans to set up a total of 295 village pharmacies throughout the Maritime, Plateau and Savanes Regions.

GTZ, the German organization for technical cooperation, has been assisting the MOH set up a cost recovery program in the Central Region within the framework of a \$4 million Health sector Restructuring Program, which includes a long term technical assistance team based in Sokode. The team has been helping MOH and community personnel set up inventory control, accounting and health information systems. An initial supply of generic drugs have been provided to 12 village pharmacies, where they are resold at a 200% mark-up. GTZ will be working jointly with the FAC to expand cost recovery activities to all health centers and dispensaries in the Plateau and Central Regions by 1994.

4. USAID Funded Cost Recovery Activities.

A major thrust of both the USAID funded HAPSS non-project assistance and the TCSP project is increasing the availability of essential drugs and the establishment of a nationwide cost recovery program in 400 MOH health centers. In conjunction with the development of the programs, USAID funded a health care financing study exploring the feasibility of cost recovery. In addition, the HAPSS document includes an analysis of the potential economic impact of breaking the TOGOPharma monopoly. Because these analyses have some relevance not only in the public sector, but also to cost recovery activities in NGO health facilities, they are briefly examined in the following paragraphs.

Christopher Schwabe of MCDI conducted an econometric analysis of the demand for curative health services based on a household health expenditure survey and a health facility study carried out in Klotu prefecture during 1991. Using a model which examines demand as a function of age, sex, education, income, medical need and the price of health services, he concludes that curative care including drugs, is a normal good, i.e., one for which the quantity demanded varies inversely with price. In general, demand was found to be price-inelastic. In other words, a decrease in price would result in a less than proportional increase in the quantity demanded. However, demand was found to be less inelastic among lower socioeconomic groups. Additionally, the study concluded that demand is income elastic; increases in disposable income are accompanied by a more than proportional increase in health care expenditures.

These findings are consistent with numerous recent studies of health services demand in the Third World. In short, reducing the price of drugs by switching to generics will result in an increase in health services utilization, especially by lower socioeconomic groups. Because demand is price-inelastic, the increase in health services utilization will nevertheless leave consumers with more disposable income to spend on other goods and services.

The economic analysis included in the HAPSS document uses a basic theoretical monopoly model to examine the effects of eliminating restrictions on the importation of pharmaceutical products. According to this model, the monopoly behaves like a firm under perfect competition, seeking to maximize profit by procuring inputs and producing outputs at lowest cost, and by producing to the

output level at which marginal cost equals marginal revenue. Beyond this level, additional output would generate greater cost than revenue, thereby reducing profits.

Unlike the firm in the perfectly competitive market, which can sell all of its output without affecting the market price, the monopoly faces a downwardly sloping demand curve and must therefore decrease its price to increase sales. As a consequence, the point at which marginal revenue equals marginal cost occurs at a lower output level and at a higher price than under perfect competition. Opening the market would therefore permit output to expand and price to drop to an optimum level, at which point the marginal social value of the output would equal the marginal social cost of its production. Applying this model to drug procurement in Togo, the study concludes that breaking the TOGOPharma monopoly could result in a reduction in drug prices of up to 80% and a concomitant increase in the quantity of drugs sold of up to 300%.

On the surface this analysis appears sound, but it is clearly inconsistent with Schwabe's conclusion that demand is price inelastic. If this were the case, TOGOPharma could increase its profit as a monopolist by raising its prices and further limiting output. Under closer scrutiny, it is clear that many of the assumptions underlying the applicability of the monopoly model do not apply in the case of TOGOPharma.

Nevertheless, the decision to shift from high cost proprietary drugs to equally effective but lower cost generics is clearly justified, as is amply documented elsewhere in the health care literature. Indeed, one must ask why the MOH has persisted in purchasing high cost drugs from TOGOPharma when, as a major purchaser, it could have insisted on lower cost generics.

Although there is general consensus on the advisability of improving the availability of low cost generic drugs and on the potential payoff of the cost recovery initiatives described above, there has been little progress in improving drug supplies and the future of the cost recovery initiatives is in doubt.

Because of the current political instability a number of donors have suspended their assistance and future support for some of the Bamako Initiative type projects is uncertain. Even in areas where village pharmacies have been established and cost recovery activities have been initiated, survival of these programs is jeopardized by the continued unavailability of low cost generic drugs. This problem is further compounded by the lack of qualified staff in several public sector facilities. According to the regional medical director in Dapaong, only 19 of 35 health centers in his jurisdiction are staffed with nurses. Of these, 17 had set up cost recovery programs with revolving funds. While these centers may have funds, they have no source of low cost drugs. Unless drug availability is improved, these initiatives may never achieve their objectives.

TABLE C.1
HEALTH INFORMATION SYSTEM: OCDI/EET HEALTH FACILITIES

HOSPITALS	POPDATA BASE	REPORTS		INTERNAL	INFO SHARING
		MOH	DONOR		
AFAGNAN	NA	UTIL	MONTHLY	ANNUAL	OCDI
AGOU-NYOGBO	NA	UTIL	MONTHLY	YES	OCDI/EET
TSIKO	NA	UTIL	MONTHLY	YES	NO
PAGALA	NA	NA	MONTHLY	NA	OCDI
GLEI	NO	NO	NO	NO	NO
KOLOWARE	NA	UTIL	MONTHLY	GTZ	GTZOCDI
ALEDJO	NA	UTIL	NO?	ANNUAL	OCDI
DAPAONG	NA	NA	YES	ANNUAL	OCDI
KANTE	NA	NA	MONTHLY	ANNUAL	OCDI
DISPENSARIES					
KOUVE	NA	NA	MONTHLY	IF REQ	OCDI
LOME-DJIDOLE	NA	UTIL	NA	NA	NA
PEDAKONDJI	NA	UTIL	NA	ANNUAL	OCDI
DZON-KOTORA	NA	UTIL	NA	NA	OCDI
KATIVOU	NA	UTIL	MONTHLY	NA	OCDI
YAKOPE	NA	NA	MONTHLY	NA	GTZMOH
BAGA	ANNUAL?	NA	MONTHLY	NA	OCDI+
COLLEGE ADELE	NO	NO	NO	NO	OCDI
KAMBOLE	NA	NA	MONTHLY	NA	OCDIGTZ
BIANKOURI	NA	NA	MONTHLY	ANNUAL	NO
NADJUNDI	NA	NA	MONTHLY	ANNUAL	OCDI
PMI'S					
OGNON	NA	UTIL	NO	NA	OCDI
BASSAR	NA	NA	MONTHLY	NA	OCDI
BORGOU-OGARO	NA	NA	MONTHLY	NA	OCDI
KPANA	NO	NO	NO	NO	OCDI
KPADOINE	NO	NO	NO	NO	OCDI
DALWAK	NO	NO	NO	NO	OCDI
KORBONGOU	NA	UTIL	NO	NO	DIOCESE
BOGOU	NA	NA	MONTHLY	NO	OCDIMOH
MANGO	NA	NA	MONTHLY	CARITAS	OCDI
TEMBERMA	NA	NA	MONTHLY	NO	OCDI
HEALTH POSTS					
LOME-TOKOIN	NA	NA	NA	OCDI	OCDI
AKODESSEWA	NA	YES	NO	NA	AFAGNAN
GBODJOME	NA	NA	MONTHLY	NA	MOH
PORTO-SEGURO	NA	NO	NO	OCDI	MOH
TOMEGBA	NA	NA	MONTHLY	NA	OCDI
YAKA	NA	UTIL	MONTHLY	NA	OCDI
LASSA-HAUT	NA	UTIL	NO	NO	OCDIMOH
PAGOUDA	NO	NO	NO	NO	NO

TABLE C.2
COST RECOVERY SUMMARY: OCDI/EET FACILITIES

FACILITIES	F CFA			COST RECOVERY			
	TOTAL COSTS	FEE REV	DONOR CONTR	CONS	MED/SUPPL.	PROC.	OTHE R
HOSPITALS							
AFAGNAN	NA	30%	70%	Y	Y	Y	HOSP
AGOU-NYOGBO	140 M	110 M	30 M	Y	Y	Y	HOSP
TSIKO	2 M	NA	YES	Y	Y	Y	HOSP
PAGALA	16 M	NA	YES	Y	Y	Y	HOSP
GLEI	NA	NA	V.IMP	Y	Y	Y	HOSP
KOLOWARE	5 M?	NA	2 M	N	Y	N	Y
ALEDJO	NA	MIN	CONG	MIN	MIN	MIN	MIN
DAPAONG	48 M	16 M	CONG	MIN	MIN	NA	NA
KANTE	NA	NA	CONG	MIN	MIN	NA	NA
DISPENS.							
KOUVE	22M	NA	CRS,+	MIN	2-300F	NO	NO
LOME-DJID	NA	NA	YES	1000F	NO	NO	NO
PEDAKONDJ	1-2 M	NA	YES	400 F	Y	NO	NO
DZON-KOT	4 M	4 M	OCDI	Y	Y	NA	NA
KATIVOU	NA	MIN	EZE,+	MIN	MIN	MIN	MIN
YAKOPE	NA	NA	CARIT	175 F	Y	NO	NO
BAGA	5.5 M	NA	YES	Y	Y	NA	NA
COLADELE	4 M	NA	OCDI+	Y	Y	NA	NA
KAMBOLE	NA	NA	OCDI	Y	Y	NA	NA
BIANKOURI	7.5 M	NA	YES	NO	Y	Y	Y
NADJUNDI	10 M	NA	YES	MIN	MIN	MIN	MIN
PMI'S							
OGNON	NA	50 K	NO	NO	Y	NO	NO
BASSAR	NA	NA	CRS,+	NO	Y	NO	NO
BORGOU	NA	NA	NA	MIN	MIN	MIN	MIN
KPANA	NA	NA	YES	MIN	MIN	MIN	MIN
KPADOINE	NA	NA	YES	MIN	MIN	MIN	MIN
DALWAK	NA	NA	CCF,+	MIN	MIN	MIN	MIN
KORBONGOU	8 M	6 M	CAR,+	Y	Y	Y	Y
BOGOU	NA	4 M	CONG	Y	Y	Y	Y
MANGO	2 M	NA	CAR,+	MIN	MIN	MIN	MIN
TEMBERMA	NA	NA	OCDI	MIN	MIN	MIN	MIN
H. POSTS							
LOME-TOK	NA	NA	CAR,+	SEE	T.CR-2		
AKODESS'A	1.2 M	NA	CRS	250F	NA	NA	NA
GBODJOME	700 K	NA	OCDI	NO	MIN	NA	NA
P-SEGURO	2.3 M	NA	CAR	NO	Y	NA	NA
TOMEGBE	NA	600 K	ATBEF	MIN	MIN	MIN	MIN
YAKA	NA	NA	PRIV	SOME	SOME	NA	NA
LASSA-HAU	NO	CHAR	PRIV	MIN	MIN	MIN	MIN
PAGOUDA	NO	NO	NO	NO	NO	NO	NO

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TABLE C.3
COST RECOVERY SUMMARY: OCDI/EET HEALTH FACILITIES

HOSPITALS	REMARKS
AFAGNAN	CHARGE 1000 FCFA/HOSP DAY AND FLAT FEE FOR CONS
AGOU-NYOGBO	EVERYBODY BILLED EXC VERY POOR
TSIKO	NOTHING IS FREE. 40% UNPAID IP BALANCE
PAGALA	EVERYTHING IS BILLED BUT AT LESS THAN COST
GLEI	MINIMAL CHARGES, LOW COST RECOVERY
KOLOWARE	5000 F FOR TB CARE; 3 M FCFA FROM GOT
ALEDJO	MOSTLY BENEVOLENT
DAPAONG	CHARGE SMALL AMOUNTS; 300 FCFA/CONS
KANTE	CHARGE SOMETHING FOR HOSP AND CONS
DISPENSARI	
KOUVE	SMALL CONTR FOR CONS
LOME-DJID	1500 F DURING OFF DUTY HOURS
PEDAKONDJ	GOOD RETURN ON MEDS; BAMAKO INITIATIVE
DZON-KOT	2.4 M FOR STAFF; REST FOR MEDS
KATIVOU	CHARGES LESS THAN COSTS
YAKOPE	
BAGA	CHARGE FOR ALL SERVICES
COL ADELE	SMALL PARTICIPATION REQUIRED
KAMBOLE	
BIANKOURI	
NADJUNDI	ASK FOR CONTRIBUTION
PMI'S	
OGNON	USE RECEIPTS TO RUN CENTER
BASSAR	CHARGE FOR MEDS ONLY
BORGOU	ASK FOR SOME PARTICIPATION (50 F)
KPANA	ASK FOR A PARTICIPATION FEE
KPADOINE	ASK FOR A PARTICIPATION FEE
DALWAK	ASK FOR MONETARY PARTICIPATION
KORBONGOU	BASICALLY SELF FINANCED; SELL MEDS, ASK FOR CONTR
BOGOU	REQUEST A CONTRIBUTION FEE
MANGO	CR ON A SMALL SCALE
TEMBERMA	CHARGE 50 FCFA FOR PMI
H. POSTS	
LOME-TOK	2000 F PER CHILD PER MONTH
AKODESS'A	CHARGE 20-40% OF THE COST OF MEDS
GBODJOME	CONS FREE; DRUGS AT REDUCED PRICE
P.-SEGURO	CHARGE FOR MEDS, NOT CONS
TOMEGBE	VERY LITTLE IF ANY
YAKA	REQUIRE AT LEAST PARTIAL PAYMENT
LASSA-HAU	ASK FOR SMALL PARTICIPATION
PAGOUDA	ASK FOR SMALL PARTICIPATION FEE

Annex D: FAMILY PLANNING SERVICE DELIVERY SITES

MARITIME PREFECTURE	SITES	STRUCTURES	METHODS
Golfe	Adakpame Adidogome Agoenyive ATBEF BE Casablanca CC Tokoin C. Sante Lome N'Kafu Camp Rit Zongo Nyekonakpoe Kodjoviakope	Dispensary " " MCH/FP clinic Health center MCH center Community ctr Health center MCH center " " " "	All methods in all centers
Ave	Assahoun	-	-
Lacs	Aneho Matern Aneho S.S. Agoegan Agomeglizou Aveve Djeta Zowla	Prefecture Hos Polyclinic Dispensary " " " "	All methods " All but IUD " " " "
Vo	Vogan Togoville Hahatoe Amegnrnan Akoumape	Prefecture Hos Dispensary " " "	All methods All but IUD " " "
Yoto	Tabligbo Tchekpo-Dedekp Tomety-Kondji Tokpli Zafi Kouve	Prefecture Hos Dispensary " " " "	All methods All but IUD " " " "
Zio	Tsevie Matern Tsevie MCH Cln	Prefecture Hos Polyclinic	All methods "
PLATEAUX			
Haho	Notse Tahoun	Prefecture Hos Health center	All methods "
Kloto	Kpalime Matern	Prefecture Hos	All methods
Agou	Agou Gare Agou Nyogbo	Dispensary Prosestant Hos	All but IUD All methods
Dayes	-	-	-
Amou	Amlame Amouoblo	Prefecture Hos Health center	All methods "

Est-Mono	Elavagnon	Prefecture Hos	All methods
Wawa	Badou	Prefecture Hos	All methods
Ogou	Atakpame Mater Atakpame MCH Cn	Regional Hos Regional Hos	All methods "
CENTRAL			
Tchamba	Tchamba	Prefecture Hos	All methods
Tchaoudjo	Sokode Matern Sokode MCH Cn	Regional Hos Polyclinic	All methods "
Blitta	-	-	-
Sotouboua	Sotouboua	Prefecture Hos	All methods
KARA			
Assoli	Bafilo Dako Gande Koumonde	Prefecture Hos Dispensary " "	All methods All but IUD " "
Bassar	Bassar Baghan bandjeli Kabou Bitchabe	Prefecture Hos Dispensary " " "	All methods All but IUD " " "
Dankpen	Guerin-Kouka		All methods
Binah	Pagouda Ketao Sirka	Prefecture Hos Dispensary "	All methods All but IUD "
Doufelgou	Niamtougou Defale Kadjalla Siou Tenega Pouda	Prefecture Hos Health center Dispensary " " " "	All methods All but IUD " " " "
Keran	Kante Nadoba	Prefecture Hos Dispensary	All methods All but IUD
Kozah	Kara Kara MCH Cn Pya Yade-Bohou Koumea Atchambade Awandjelo Djambe Lama Kpeda Landa Lassas-Bas Soundina Haut	Regional Hos Social Center Health center " " Dispensary " " " " " "	All methods " " " " All but IUD " " " " " "

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SAVANES Tandjoare			
Oti	Mango	Prefecture Hos	All methods
Kpendjal	Mandouri	Prefecture Hos	All methods
Tone	Dapaong Matern Dapaong S.S.	Regional Hos Polyclinic	All methods "