PD-ABP-635
95271

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE: A (A = Add, C = Change, D = Delete)

Amendment Number

DOCUMENT CODE: 3

2. COUNTRY/ENTITY: TOGO

3. PROJECT NUMBER: 693-0228

4. BUREAU/OFFICE: USAID/Togo

5. PROJECT TITLE (maximum 40 characters): Health Sector Support for Child Survival

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM 09 DD 30 YY 91

7. ESTIMATED DATE OF OBLIGATION (Under "B." below, enter 1, 2, 3, or 4)

A. Initial FY 87 B. Quarter 3 C. Final FY 90

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

A. FUNDING SOURCE	FIRST FY B. FX	C. L/C	D. Total	LIFE OF PROJECT E. FX	F. L/C	G. Total
AID Appropriated Total	911	–	911	4,500	–	4,500
Grant)	(911)	(–)	(911)	(4,500)	(–)	(4,500)
Loan)	(–)	(–)	(–)	(–)	(–)	(–)
Other U.S. 1. Reob	750	–	750			
U.S. 2.						
Host Country		100	100		2,200	2,200
Other Donor(s)						
TOTALS	1,661	100	1,761	4,500	2,200	6,700

9. SCHEDULE OF AID FUNDING ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	2. Loan	D. OBLIGATIONS TO DATE 1. Grant	2. Loan	E. AMOUNT APPROVED THIS ACTION 1. Grant	2. Loan	F. LIFE OF PROJECT 1. Grant	2. Loan
(1)									
(2) PN	400	450				–		800	
(3) ESF	580	520				1,661		3,700	
(4)									
TOTALS						1,661		4,500	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each): 530, 562

11. SECONDARY PURPOSE CODE

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code: CS

B. Amount: 4,500

13. PROJECT PURPOSE (maximum 480 characters)

To improve the capability of the MOH to plan, manage, and coordinate the delivery of Child Survival services in a rational, cost-effective way.

14. SCHEDULED EVALUATIONS

Interim MM 06 YY 89 MM YY Final MM 01 YY 91

15. SOURCE/ORIGIN OF GOODS AND SERVICES

☒ 000 ☒ 941 ☒ Local ☐ Other (Specify)

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

17. APPROVED BY

Signature

Title: Mark G. Wentling
AID Representative/Togo-Benin

Date Signed: MM 08 DD 21 YY 87

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

MM DD YY

REDSO/WCA WAAC Controller concurrence per Abidjan 18930 dtd Aug. 27, 1987

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EXECUTIVE SUMMARY

Togo Health Sector Support for Child Survival Project (693-0228)

This is a four year, $4,500,000 project which will provide insititutional support to the Ministry of Public Health, Social Affairs, and Women's Condition. With this support, the MOH will be able to plan, manage, and coordinate delivery of Child Survival services in a rational, cost-effective way.

The project consists of three components. The first, the Planning and Coordination Component, will build a Togolese capacity to plan, budget, manage, and coordinate Child Survival-related activities. Through a Planning and Coordination Unit reporting to the Minister of Health, this component's funding will train MOH officials in planning and budgeting and assist in drafting a Child Survival policy and strategy statement, a training plan and budget, and a Child Survival activities inventory and needs assessment.

The second component, the Health Centers Support Component, focuses on Public Health staff working at Health Centers, instructing them in effective interpersonal approaches and adult health education techniques for use with their clients, and in the substance, efficacy, and promotion of Child Survival measures. This component follows a training-of-trainers approach, and funds the training (by long- and short-term technical assistants and by cooperating agency personnel) and logistic support of 42 members of Prefecture Health Education Teams created by the National Health Education Service by drawing from the ranks of Public Health Personnel. These Team personnel, as "trained trainers," in turn will instruct Public Health staff in every Togolese prefecture using project-funded Information-Education-Communications (IEC) materials.

The third component, the Outreach Network Component, in addition to the second component's instruction of Public Health personnel, undertakes village outreach activities in the Plateaux and Savanne regions where organizational linkages and villager commitment to community development tend to be more advanced and productive than in other regions, due largely to the head start given these areas by participation in the A.I.D.-financed Rural Water Supply and Sanitation Project activities. This component will fund the training and logistic support of 120 Community Agents (Social Affairs and Sanitation field workers). Training of this group will be in advanced community mobilization techniques and in Child Survival topics and be provided by long- and short-term technical assistants and by cooperating agency personnel. The component also will fund Child Survival Field Days to instruct groups of villagers from several communities in Child Survival topics.

The second and third components support the first by fostering the conditions which a comprehensive, cohesive, well-planned, and prudently budgeted Child Survival Program requires for successful implementation.

Expatriate long-term technical assistance personnel consists of a Senior Advisor/Health Planner, an Information-Education-Communications (IEC) Specialist (both under contract with a U.S. firm having 8A status), and an Agents' Coordinator (under a Personel Services Contract). Key Togolese project-financed personnel involved in project implementation will be the Child Survival Unit Director (a GOT official with training and experience in planning and management) and the Teams' Coordinator (a Togolese experienced in health outreach administration under a Personal Services Contract). Other key Togolese personnel involved in implementation will be two senior MOH officials seconded to the Planning and Coordination Unit to serve as Unit Coordinators, and the 42 Prefecture Health Education Team members and 120 Community Agents discussed above. These personnel will be supplemented by resources provided pursuant to Collaborative Protocols with GOT entities, donors, PVOs, and religious organizations having training skills, technical expertise, and appropriate IEC materials to contribute to project activities.

Significant project financing other than for technical assistance includes that for IEC materials, motorcycles for Teams and Agents, vehicles, petrol, oil, lubricants, Unit operating expenses, local training costs, limited U.S. degree training, limited, modest construction, two evaluations, and an audit.

Successful project implementation will result in the following:

--an MOH planning and budgeting exercise pertaining to Child Survial activities will be undertaken annually, led by the Unit;

--the Unit's serving as a multipurpose clearinghouse for Child Survival activities, the planning and budgeting process, and outreach network efforts will maximize the beneficial impact of the resources available for Child Survival;

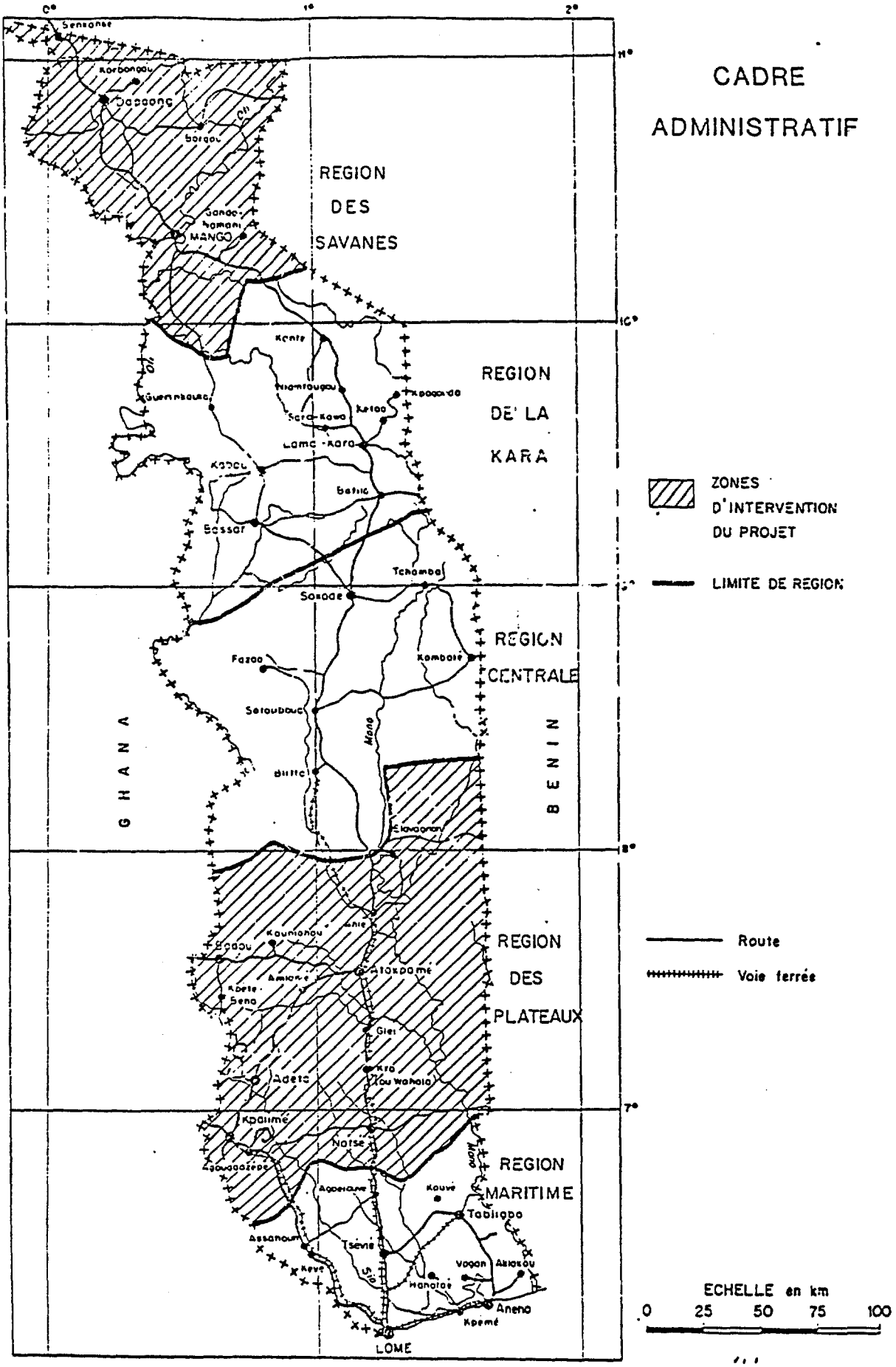
--MOH priorities, rather than donor preferences, will determine investments in Child Survival;

--Public Health staff's communications and technical skills will be upgraded;

--villagers nation-wide will be informed and will avail themselves of Child Survival services at Health Centers, and undertake appropriate Child Survival measures at home;

--villagers in isolated areas of Plateaux and Savanne will be informed about Child Survival, able to perform home-administerable techniques, and aware of options for obtaining more sophisticated services; and,

--a four-element health outreach network in Plateaux and Savanne will operate to provide and continually improve health education and service delivery, the four elements being Prefecture Health Education Teams, Health Center-based Public Health personnel, Community Agents, and Village Development Committees.


CADRE
ADMINISTRATIF
REGION
DES
SAVANES
REGION
DE LA
KARA
REGION
CENTRALE
REGION
DES
PLATEAUX
REGION
MARITIME
GHANA
BENIN
MANGO
Sansanne
Dapaong
Borgou
Kara
Bassar
Sokodé
Kamboïé
Fazao
Atakpamé
Aného
Tabligbo
Tsévié
Vogan
Aného
Kpémé
LOME
ZONES
D'INTERVENTION
DU PROJET
LIMITE DE REGION
Route
Voie ferrée
ECHELLE en km
0 25 50 75 100

LIST OF ACRONYMS

ATBEF	Association Togolaise pour le Bien-Etre Familial
CBD	Community Based Delivery
CCCD	Combatting Childhood Communicable Diseases
CDC	Center for Disease Control
CHR	Regional Hospital Center
CHU	University Hospital Center
CIDA	Canadian International Development Agency
CRS	Catholic Relief Services
CS	Child Survival
CSP	Primary Health Care Center
CUSO	Canadian PVO
DG	Director General
EPI	Expanded Program for Immunization
FED	European Development Fund
FHI-II	Family Health Initiative
FHTC	Family Health Training Center
FPIA	Family Planning International Assistance
GDP	Gross Domestic Product
GM/P	Growth Monitory/Promotion
GNP	Gross National Product
GOT	Government of Togo
HCC	Host Country Contact
HIS	Health Information System
IBRD	International Bank for Reconstruction and Development
IEC	Information, Education and Communication
KAP	Knowledge, Attitudes and Practices
MCH	Mother and Child Health
MOH	Ministry of Health
MOP	Ministry of Plan
NAPRO	National Application Program
NGO	Non-Government Organization
ORT	Oral Rehydration Therapy
PH	Public Health
PHC	Primary Health Care
PNBEF	Programme National pour le Bien-Etre Familial
PSC	Personal Services Contractor
PVO	Private Voluntary Organization
RAPID	Resources for the Awareness of Population Impacts on Development
RPT	Rassemblement du Peuple Togolais
RWSS	Rural Water Supply and Sanitation Project
SA	Social Affairs
SNES	National Health Education Service
SPSS	Small Program Strategy Statement
TOT	Training of Trainers
UCI	Universal Childhood Immunization
VDC	Village Development Committee
WB	World Bank
WHO	World Health Organization

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SUMMARY

A. FUNDING, GRANTEE, IMPLEMENTING AGENCY, TERM OF PROJECT

This project, Togo Health Sector Support for Child Survival, 693-0228, has a proposed four year life, with funding of $4.5 million granted to the Government of Togo (GOT) pursuant to the Child Survival Fund of the Population and Health Program established under Section 104 of the Foreign Assistance Act of 1961, as amended. The GOT's Ministry of Public Health, Social Affairs, and Women's Condition (MOH) (Ministrere de la Sante Publique, Affaires Sociales, et de la Condition Feminine) is the Implementing Agency, and is expected to be signatory of the Project Agreement on behalf of the Grantee. The entity of the Implementing Agency charged with detailed monitoring and facilitating of project implementation is the Child Survival Coordination Unit to be created pursuant to this project.

B. AUTHORIZED GEOGRAPHIC CODE

Goods and services (both technical and commodity-related, such as shipping and insurance) financed by A.I.D. under this project shall have their source and origin in the Cooperating Country (Togo) and in countries included in A.I.D. Geographic Code 941, except as A.I.D. may otherwise agree in writing.

C. WAIVERS REQUIRED

A source-origin waiver from A.I.D. Geographic Code 000 to Code 935 to permit the procurement of two heavy duty sedans and one light duty sedan, one station wagon, and one utility vehicle and spare parts for each has been approved by the Assistant Administrator for Africa, and is included at Annex F.

D. PROJECT PURPOSE

The purpose of this project is: to assist the GOT to plan, manage, and coordinate the delivery of Child Survival services in a rational, cost-effective way.

E. SUMMARY BACKGROUND

In Togo the infant mortality rate is 107 and the crude death rate is 17 (as opposed to 10.5 and 9 respectively in the United States), and these figures are substantially worse in rural areas. The infant mortality rate gives the greatest cause for alarm, having increased between 1970 and 1986 from 90.2 to over 107 in rural areas. Reducing infant and child mortality and morbidity will improve these statistics and Togo's general health profile dramatically. Medical technologies to effect this improvement exist today, as do a Togolese appreciation of their efficacy and fragmented donor efforts to provide their benefits. What does not exist is a MOH planning, budgeting, and management capacity to channel the scarce resources available for health in general and for Child Survival in particular for optimal beneficial impact. There are two additional important gaps for improving infant and child health

status: Togolese public health personnel based at clinics are not skilled in health education and not sufficiently vigorous in promoting Child Survival interventions; and, Togolese villagers, especially those in remote areas, are unaware of Child Survival measures. Until Togo develops a health sector planning and coordination capacity, a Public Health staff skilled in health education and Child Survival promotion and service delivery, and an effective, operational outreach network system, MOH and donor resources are going to be under-used, misused, and, perhaps, malused. Accordingly, this project foregoes the more orthodox, prototypical Child Survival interventions of providing service delivery and support commodities, and of undertaking extensive, technically-sophisticated training, in part because other entities already are active in these areas. Instead, this project addresses building the preconditions for optimizing the benefits yielded by these othodox interventions.

F. SUMMARY PROJECT DESCRIPTION

The project consists of three components. The first, the Planning and Coordination Component, will build a Togolese capacity to plan, budget, manage, and coordinate Child Survival-related activities. Through a Planning and Coordination Unit reporting to the Minister of Health, this component's funding will train MOH officials in planning and budgeting and assist in drafting a Child Survival policy and strategy statement, a training plan and budget, and a Child Survival activities inventory and needs assessment.

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The second and third components support the first by fostering the conditions which a comprehensive, cohesive, well-planned, and prudently budgeted Child Survival Program requires for successful implementation.

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This summary description is intentionally skeletal. Readers are referred to the Detailed Project Description and to the Implementation Plan for a comprehensive discussion of the project and how it is expected to proceed.

G. SUMMARY FINANCIAL PLAN (,000)

EXPENSE CATEGORY	A.I.D.	GOT	TOTAL
Technical Assistance	$2,150	$	$2,150
Commodities	391		391
Vehicles	84		84
Training	495		495
Construction	100		100
Local Op Exp/Local Project Personnel	1,040	50	1,090
Evaluation	175		175
Audit	30		30
MOH Personnel		2,000	2,000
MOH Facilities		150	150
Contingency	35		35
TOTAL	$4,500	$2,200	$6,700

More detaled financial information is set forth in the Financial Plan and the Financial Analysis.

H. SUMMARY CONDITIONS PRECEDENT AND CONVENANTS

A limited number of conditions precedent will be included in the Project Agreement to assure that preparatory arrangements which are functional prerequisites to reasoned project implementation in fact are completed satisfactorily before the activities they support are allowed

to go forward, and to assure that a high level of GOT commitment to the project, without which purpose achievement and benefit sustainability cannot be realized, has been demonstrated. The most significant of these conditions for initial disbursement refer to: retention of accounting personnel and of the accounting system of the Rural Water Supply and Sanitation Project, establishment of a Child Survival Planning and Coordination Unit, and, GOT assignment of a Unit Director to head this Unit. A condition precedent to disbursements after the twenty fourth project month requires that an in-depth external evaluation have concluded that the GOT had manifested a high degree of commitment to the project during the first twenty one project months. A condition precedent to disbursement for construction mandates submission to A.I.D. of building plans, and materials and cost estimates.

The Project Agreement will include several covenants to formalize GOT accord to undertake specified essential actions to further project implementation. These covenants relate to: assignment of two senior MOH officials to the Unit; transfer of Rural Water Supply and Sanitation Project assets to this project; availability of that project's Community Agents and their motorcycles for this project; and, GOT payment of overhead and personnel costs of motorcycle repair facilities in Plateaux and Savanne regions.

An expanded version of these Conditions Precedent and Covenants are set forth in the "Conditions, Covenants, and Negotiating Status" sections herein.

I. SUMMARY FINDINGS

This project is ready for implementation and is considered financially, economically, socially, and environmentally sound, and technically feasible.

J. STATUTORY CHECKLISTS AND A.I.D. REPRESENTATIVE'S DETERMINATION

1. This project meets all applicable statutory criteria. Appropriate checklists are included in Annex C.

2. The A.I.D. Representative's determination authorizing local cost financing is included in Annex B.

K. PROJECT ISSUES

1. GOT Commitment to Project

The major issue emerging from the February 13, 1987 Executive Committee Project Review (ECPR) for this project's Project Identification Document (PID) was the need for demonstration of GOT commitment to this project. This issue is being resolved by including three conditions precedent in the Project Agreement. The first, a condition precedent to initial disbursement, requires GOT appointment of a qualified Child Survival Unit Director qualified in planning and management to serve full time for the life of the project, and USAID/Togo's concurrence in the appointment. The second, also a condition precedent to initial disbursement, requires establishment of the Child Survival Coordinating Unit, and a formal assurance it will exist for the life of the project. The third, a condition precedent to disbursement after the

twenty-fourth project month, mandates an in-depth external evaluation in the twenty-first project month, a major purpose of which will be to assess GOT commitment to the project and A.I.D. strategy in supporting the Planning and Coordination Unit, especially in relation to other donors' initiatives. Among the indicia of GOT commitment which will be sought are the satisfactory performance of the Unit Director and the two MOH Unit Coordinators seconded to the Unit; the formation, full operation, and effectiveness of the Unit and the Advisory Board; and the degree and promptness of cooperation forthcoming from MOH entities (such as the Divisions of Epidemiology and Material and Child Health, the National Health Education Service, and participating Social Affairs agencies) which have expertise and resources needed for optimally successful project implementation; and, the GOT's having obtained satisfactory, appropriate facilities for the Unit. This evaluation also will look for a concrete GOT plan for assuming the costs of petrol, oil, lubricants, and repairs for the motorcycles used by the Teams and Community Agents so that these groups retain their mobility after this project ends.

2. Nutritional Surveillance

The only other ECPR issue warranting discussion at this stage is the question of how nutritional surveillance will be incorporated into the project. The project will not fund nutritional surveillance as a discrete activity. To do so would duplicate the extensive efforts of Catholic Relief Services in this area. However, the project will assure that training sessions which introduce the integrated concept of Child Survival to Prefecture Health Teams and Community Agents include nutritional surveillance as one of the major topics. Also, the Child Survival Coordination Commission will assure that organizations and MOH entities active in nutritional surveillance contribute their expertise and resources to those in greatest need.

L. CONSIDERATION OF SMALL, DISADVANTAGED, AND WOMEN-OWNED FIRMS

Two long-term technical assistance personnel (a Health Planner and an IEC Specialist) will be needed for project implementation. The Mission has committed itself to a "set aside" for small, disadvantaged, and women-owned firms.

M. PROJECT TEAM MEMBERS

The project paper design efforts were carried out during April-August, 1987 by the following individuals:

Mark Wentling	A.I.D. Representative, USAID/Togo-Benin
Myron Golden	Former A.I.D. Representative, USAID/Togo-Benin
Ernest Popp	General Development Officer, USAID/Togo-Benin
Belen Baas	Economic Analyst, USAID/Togo-Benin
Vincent Brown	Health Planner
Joanne Revson	Health Trainer
Ronald Waldman	CDC/Atlanta Technical Officer
M. Tschirhart	West African Accounting Center, REDSO/WCA
Louis O'Brien	Technical Assistant, Togo Rural Water Supply and Sanitation Project
Julie Defler	Project Development Officer, REDSO/WCA

A list of persons contacted is included at Annex K.

I. BACKGROUND

A. COUNTRY SETTING

Present-day Togo incorporates the former French-administered United Nations trust territory which became independent in 1960. It is a long, narrow country of 21,853 wquare miles about the size of West Virginia, stretching 370 miles north to south and averaging 56 miles in width. It is bounded on the west by Ghana, on the east by Benin, on the north by Burkina-Fasso, and on the south by the Gulf of Benin on the Atlantic Ocean. The country has an inter-tropical climate, with two rainy seasons in the south and one in the north. There are five administrative regions, from north to south: Savanne, Kara, Centrale, Plateaux, and Maritime. Regions in turn are composed of "prefectures", which are composed of cantons. Thereafter follows a series of increasingly smaller local communities. A north-south, all season road connects major population centers.

B. HEALTH PROFILE

Over the last decade Togo's health status indicators have changed little. According to the Population Reference Bureau, 1987 indicators (with United States data to facilitate comparison) are:

Indicator	Togo	USA
Crude Birth Rate (annual number of births per 1000 population)	47	16
Crude Death Rate (annual number of deaths per 1000 population)	15	9
Infant Mortality Rate (annual number of deaths of children under age 1 yr. per 1000 live-births)	117	10.5
Life Expectancy at Birth	53	75 1/

The indicator giving the greatest cause for alarm is the infant mortality rate which has increased from 90.2 in 1970 and to well over 107 in rural areas. The leading causes of infant and child mortality and morbidity are:

- malaria;
- diarrheal-intestinal and parasitic disorders, e.g., onchocercosis (river blindness), dracunculosis (Guinea worm), schistosomiasis, trypanosomiasis (sleeping sickness);
- broncho-pulmonary diseases;
- malnutritional; and,

1/ For purposes of this paper, "infant" shall mean a person aged 0-1 year and "child" shall mean a person aged 0-5 years.

- measles and other infectious diseases, such as polio, pertussis (whopping cough), tetanus, diptheria, and tuberculosis.

Another major health problem in Togo is maternal mortality. Although poorly documented, data from regional hospital centers indicates it is relatively high due to insufficiently spaced births, low marriage age, and the consequently high number of births per woman.

C. DEMOGRAPHIC PROFILE

The mid-1986 population estimate for Togo was 3 million, 72.5 percent of which was rural. Other salient demographic figures (with those from the United States for comparison) are:

Indicator	Togo	U.S.
Rate of Natural Increase (RNI, annual population growth)	3.1%/yr.	0.7
Population Doubling Time (at current RNI)	22 years	99
Total Fertility Rate (average number of children per woman)	6.2	1.8
Percent of Population under age 15/over age 65 ("dependent ages" or economic burden carried by population of working age)	45/3%	22/12%
Percent of population under 5 years	20%	Not available
Percent of population who are women of childbearing age	20%	Not available

In 1983 the overall illiteracy rate of 67.7 percent, while that for females was 80.7 percent.

D. IMPACT OF THE FINANCIAL SITUATION ON THE HEALTH SECTOR

The major economic and financial problem currently facing Togo is a large foreign debt. In the mid-1970's, high prices for commodities exported by Togo brought in substantial foreign exchange. The government increased its own investment, often in enterprises requiring it to pay large recurrent costs as well as debt service. When commodity prices fell, the government's revenues and foreign exchange intake also fell,

but its spending did not, resulting in a large fiscal imbalance and balance of payments problem. Years of negative economic growth preceded the 1982 IMF structural readjustment, which involved investment cuts and a personnel freeze. Servicing the debt has used a high percentage of the Togolese annual budget: 46 percent in 1984, 58 percent in 1985, and 59 percent in 1986. This burden will remain: only in 1989 does the debt service begin to decrease, and even then it is higher than it was in 1983. Also, in 1986 the debt to export ratio was 49 percent. These figures indicate that resources that can be devoted to development are very limited.

The natural tendency is to allocate these scarce resources for income-generating or cost reduction activities (such as cash crops), rather than for undertaking what seem to be income-draining activities, such as health service delivery. This tendency has manifested itself, and the health share of shrinking public sector resources is decreasing. The health budget has declined 40 percent in real terms between 1978 an 1983. The health budget as a percent of the total GOT budget declined progressively from 7.55 percent in 1984 to 6.04 percent in 1985 to 5.77 percent in 1986. A consequence of these figures is that the ratio between materials and personnel costs has decreased from .40 in 1984 to .216 in 1986. Currently, 80 percent of the health budget is allocated to personnel, but the budget squeeze means those prsonnel have less material resources available to them to do their jobs. For instance, itinerant health agents may be short of petrol or may not have broken bicycles repaired or replaced. Drug stocks are incomplete and low, and health facilities are minimally equipped.

A major casualty of health budget restrictions has been training, which has decreased and in some cases stopped since the 1982 personnel freeze. Paramedical schools have closed and all paramedical training has been discontinued. An institute which has the capacity to train 30 nurses a year in midwifery now only offers refresher courses for already-trained staff. The medical school has reduced admissions from 40 to 15 a year and only two graduates were employed in 1986 by the MOH. Not only are staff less well trained, but they are fewer in number as a consequence of the personnel freeze, attrition, and budget restrictions. For example, the already overburdened Maternal and Child Health Agents who each were responsible for 1,289 children an women of childbrearing age in 1984 became responsible for 1,508 persons in 1985.

Generally, the austerity measures imposed by the GOT (some mandated by the IMF) have prevented the expansion of health facilities and service delivery and sometimes have eroded earlier achievements. The potential for charging user fees for services to offset the scarcity of public funds devoted to health is limited in light of the per capita 1983 GNP of $280. In this context, judicious use of scarce resources for optimal beneficial impact in the health sctor must be a high GOT priority.

E. HEALTH SECTOR INSTITUTIONS AND STAFF

1. Administrative

a. National Level

The Ministry of Public Health, Social Affairs, and Women's Condition (MOH) is responsible for Togo's public sector health programs. It has three "Directorates" as its name implies, of which Public Health usually is the dominant. A series of MOH organizational charts is included at Annex M.

(1) Directorate of Public Health

The Directorate of Public Health has eight divisions. Those which have an important role to play in this project include:

--The Epidemiology Division, which conducts vaccination campaigns, combats malaria, tuberculosis, and other endemic diseases, and manages the Health Information System.

--The Division of Mother and Child Health, includes some 350 MCH Centers which are active in ORT, growth monitoring, weaning foods, and voluntary birth spacing.

--The Division of Public Hygiene and Health Promotion, which is active in hygiene, sanitation, health education, mass media "information-education-communication" (IEC) campaigns, non-academic training of health personnel, and the recently critical fight against AIDS. The National Health Education Service, which is of central importance to this project, is placed within this division.

--Other Divisions of the Public Health Directorate are: Health Services (overseeing hospitals, health centers, dispensaries and paramedical personnel; Pharmaceuticals; Administrative and Financial Service; Laboratories; and Professional Training (for academic training).

(2) The Directorate of Social Affairs and the Directorate of Women's Condition

The Directorate of Socials Affairs has five substantive divisions at the national level, the most significant for this project being the Division of Community Development which has community mobilization responsibilities. The Directorate for Women's Condntion has four Divisions, with the Social Education division being the most important for this project.

b. Regional Level

Only the Directorates of Social Affairs and Women's Condition have regional headquarters. The absence of regional organization (as opposed to regional hospitals, which do exist) for Public Health has long been seen as one of this directorate's serious shortcomings, resulting in diffused lines of communication and difficulty

in collaborating with other GOT agencies in the field. The MOH plans to establish regional headquarters for Public Health with the help of a World Bank-funded organizational strengthening effort. See the proposed MOH organization at Annex M. Regarding the current structure of the Public Health Directorate, it should be noted that two sub-divisions of the Division of Public Hygiene and Health Promotion, the National Health Education Service and the Sanitation Service, have regional-level organizations, although that for Health Education remains to be fully developed.

c. Local Levels

Regions are divided into subdivisions (the health sector unit corresponding to the prefecture), which ultimately are composed of villages. At local levels, the activities of Public Health Agents (functionally, Health Workers) and Social Affairs Agents (functionally, Social Workers) often overlap, with Health taking the lead in such areas as vaccination and malaria treatment and Social Affairs (often collaborating with Public Health's Sanitation Agents) taking the lead in community mobilization, and general development. There is a good deal of shared territory, especially in medically less technical areas such as health education, nutritional surveillance, and some ORT efforts. This overlap is a natural consequence of a small total number of local level agents from both Directorates being responsible for information transmittal and some service delivery to village clientele: any given agent must be familiar with a broad range of ministry services.

2. Health Service Delivery Facilities

The Health Services Division of the Directorate of Public Health classifies its facilities as follows:

-- the National University Hospital Center or CHU (Centre Hospitalier Universitaire) in Lome, a full service hospital;

-- Regional Hospital Centers or CHRs (Centre Hospitalier Regional) of which there are four. The prototype delivers four basic services: general medicine, surgery, obstetrics, and pediatrics. Two additional services also are provided -- stomatology and basic radiology.

-- Subdivision Hospitals at the prefecture or subdivision level in prefectures not served by the CHU or a CHR. There are 16 of these hospitals typically offering medical consultations, minor surgery, hospitalization in general medicine, obstetrics, and surgery, and laboratory services. The Chief Doctor at each is responsible for preventive health care programs, such as vaccination, and for the administration of all health service delivery units in his subdivision. These local units include:

-- Primary Health Centers or CSPs (Centre de Sante Primaire), which can provide almost as many services as a Subdivision Hospital, but usually are more limited. They number about 34 and operate at the subdivision level;

— Dispensaries, or Secondary Health Centers with an attached Maternal and Child Health (MCH) Center. These number about 286 and focus on preventive medicine and health education. They are supervised by a state nurse; and,

-- MCH Centers not associated with dispensaries of which there are 56, managed by midwives instead of state nurses.

3. Personnel Involved in Health Service Delivery

Among the categories of personnel employed by the Directorate of Public Health are:

— Chief Medical Officers: always physicians, with administrative and supervisory as well as service delivery responsibilities;

-- Medical Assistants: qualified nurses with three additional years of training who stand in for Chief Medical Officers when necessary;

— State Nurses: variously categorized by training level, who are in charge of dispensaries;

— Auxilliary Nurses: assistants to State Nurses. They are being phased out by attrition with the closing of paramedical training facilities (an economy measure);

-- Hygiene Assistants: variously categorized by training level, who focus on preventive measures, environmental sanitation, and other public health activities (such as vaccination). They also are being phased out by attrition with the suspension of paramedical activities;

— Midwives: with three years' training, who work in rural MCH Clinics; and,

— Birth Attendants: trained by apprenticeship to assist midwives.

— Itinerant Health Workers, trained by Chief Medical Officers to serve as nurses aides, who work out of dispensaries performing mainly educational and promotional activities. At present they are itinerant in varying degrees depending on the availability f petrol. They usually are provided with bicycles which are insufficient for going long distances over rough terrain.

The above categories of Public Health personnel number about 2,200. A 1982 IMF-imposed personnel freeze on recruitment, closing of health paramedical training facilities in 1983, and a 1985 forced early retirement scheme, have reduced substantially the number and quality of personnel available for health service delivery. Moreover, the ineffective deployment of personnel that remain has been reported to be a more serious problem than dwindling numbers. One major concern is that about 63 percent of the MOH's Public Health employees are based in Lome, leaving rural areas understaffed.

4. Personnel Involved in Community Action and Development

Health service delivery at the local level is greatly facilitated by Social Affairs Agents who mobilize communities, teach rudimentary fiscal and commodity management to Village Development Committees (VDCs), and participate in health campaigns and activities such as ORT and nutritional surveillance. They number about 500, of whom about 415 are engaged in intensive field work. They are classified as follows:

-- Social Assistants, trained in France, Senegal, and the Ivory Coast;
-- Specialized Educators, trained in France;
-- Socio-Medical ASsistants, trained in the Ivory Coast;
-- Development Technicians, trained in the Cameroon;
-- Social Promotion Agents (numbering about 400), trained in Lome; and,
-- Social Motivators trained on-the-job.

The personnel groups of primary importance for this project are Social Promotion Agents and Socio-Medical Assistants.

F. POLICY CONTEXT

1. GOT

Child Survival has figured prominently in the two most recent and influential GOT policy statements on public health. The first is a policy assessment and program prioritization statement contained in the GOT's presentation to the October, 1986 Donors' Conference. This document announced the GOT's adoption of two main strategies for improving the population's health status:

-- primary health care; and,
-- planning and management.

Training of health personnel was set forth as a supporting strategy needed to accomplish the two primary strategies.

The same document also gave a prioritized ranking of health programs;

-- the enlarged vaccination program (EPI), and health information system (HIS) shared first priority;
-- mother and child health (which in Togo includes ORT and nutritional surveillance) and family health (which is understood to include birthspacing);
-- health-related information, education, and communication (IEC) on mass, small group, and individual levels;
-- potable water and sanitation (including sanitary waste disposal);
-- malaria treatment; and,
-- rehabilitation of health facilities (as opposed to new construction).

The second GOT policy statement was prepared for the meeting of francophone parliamentarians on Child Survival, Population, and Development held in Abidjan in March, 1987. It stressed the importance of family planning education and the necessity of integrating family planning services into those provided by MCH Centers and general primary health care facilities. It further emphasized the high priority of vaccination and ORT in the national primary health care program, and mentioned breast feeding, good weaning practices, and nutritional surveillance as other important elements.

Furthermore, a December, 1986 statement at the Togolese Political Party (RPT) Congress laid the groundwork for progress in two additional areas of importance for this project. The statement reaffirmed the policy articulated at the October, 1986 Donors' Conference and proceeded to assert that health personnel must improve their public relations and ambiance with clients, and that clients should share in the cost of health care.

2. A.I.D.

The Agency has given Child Survival activities highest priority in the health sector with the promulgation of a Child Survival Strategy in April, 1986, and of an Action Program for Africa in November, 1986. The A.I.D. strategy seeks to sharpen the focus of the Agency's health related programs and to reduce significantly the number of preventable deaths of children in the developing world by the end of the decade. The objectives of the Africa Bureau Action Program are:

"1. To reduce morbidity and mortality in the under five population...;

2. To strengthen the capabilities of African governments and the private sector institutions to plan, implement, and evaluate programs to improve child health and survival."

The Plan's priority interventions mirror those of the GOT: ORT and immunization are the primary interventions, supported by birthspacing, a nutrition package emphasizing breast feeding, improved weaning practices, and growth monitoring, and presumptive treatment of malaria (use of antimalarial drugs, principally chloroquine, to treat acute attacks of fever inducing illness). The importance of health education and social mobilization are recognized.

Management, institution-building, and sustainability are stressed in the light of the fact that, "an unusually weak human and institutional base characterizes most African nations." This Action Program states:

> One of the most crucial aspects of child-survival projects and programs is management. Without adequate managers, all of the funds and efforts now being concentrated in this area will not result in long-term institutionalization of Child Survival interventions or, hopefully, primary health care.

This project, combining planning and management strengthening with widespread training and facilitating of appropriate village-level Child Survival interventions is entirely supportive of the Agency strategy and the Africa Bureau Action Program.

In addition, this project addresses all four A.I.D. programmatic components. Institution building and policy dialogue will be undertaken in the planning, management and coordination activities. Technology transfer will be effected by widespread project-sponsored educational activities and by the subsequent project-facilitated Child Survival interventions. The private sector will be supported by enhanced patronage of private distributors by villagers satisfying their health needs, and by deliberate, systemic incorporation of private sector enterprises into health-care manufacturing, distribution, and service provision attendant upon improved central-level planning and management of health service delivery.

3. The Office of the A.I.D. Representative, Togo

This project's focus on optimizing the efficiency and effectiveness of Togolese Child Survival service delivery is entirely consistent with the FY 1986 Update of USAID/Togo's Small Program Strategy Statement which gives, as one of the Mission's program goals: "health development through...low-cost rural health delivery systems, and a coordinated approach to population growth".

The policy statements quoted in this section demonstrate that this project's major participants' policies support project premises and activities, and are consistent with and supportive of each other.

G. PRIOR EXPERIENCE

1. GOT Programs

The GOT has attempted to conceive and execute health programs consistent with its relatively recent focus on preventive (rather than curative) health care and with the priorities set forth in its policy declarations. It now has ongoing programs for the major Child Survival interventions, but they are constrained by lack of resources, inadequately trained staff, and insufficient coordination of entities delivering health services. An overview follows.

a. The Expanded Program of Immunization (EPI)

The EPI effort strives to vaccinate 80 percent of the infants aged 0-1 years against six target diseases: diptheria, tetanus, polio, measles, tuberculosis, and whooping cough. The Division of Epidemiology is responsible for collection, storage, and distribution of vaccines, for training collection, storage, and distribution of vaccines, for training personnel, and for supervising prefecture-level programs. At this level, the prefecture hospital's chief doctor is responsible for selecting vaccination sites and programming field visits. Vaccines, maintenance of the cold chain, and transport are the main expenses, many of which are met by donors, especially UNICEF.

b. Diarrheal Disease Treatment: Oral Rehydration Therapy (ORT)

The ORT program has made significant progress in a short time. A 1983 out-patient register review showed no record of ORT use. Today it is available widely, but use is hampered by health workers unconvinced as to its effectiveness and by the population's general lack of knowledge of the technology. However, an estimated 300,000 packages of oral rehydration salts have been distributed, and village health education sessions teach the recipe and administration procedure for the home-made solution. Again, donors, have facilitated GOT efforts for this priority effort.

c. Malaria Treatment

There has been an antimalarial service in Togo for many years, but due to lack of resources there have been few control activities apart from several pilot projects. In 1981 this service developed a national strategy to reduce the rate of infant and child morbidity and mortality due to malaria. The strategy's quantifiable goals were to prevent malaria in children aged 0-5 and in pregnant women by chemoprophylaxis, but budgetary limitations necessitated reducing the chemoprophylaxis to pregnant women.

In 1983 the project for Combatting Childhood Communicable Diseases (CCCD) revived chemoprophylaxis for children aged 0-4 and for pregnant women, and began presumptive treatment of febrile cases. The WHO recommended that the preventive treatment be stopped because of growing chloroquine resistance, among other reasons, and the recommendation was followed. The program still advocates preventive treatment of pregnant and nursing women.

The current antimalaria program strives to make each village responsible for its own treatment and for preventive hygiene and waste disposal measures. To these ends there is experimentation with village pharmacies -- providing village committees with a small stock of antimalarial and other basic drugs for village sale and stock replenishment from sale proceeds.

d. Nutrition

Nutrition program activities focus on educating mothers to improve nutrition of children under five, developing a nutritious weaning flour from local materials, monitoring growth, and -- thanks to the Togo branch of the Catholic Relief Services (CRS) Cathwell program -- distributing food supplements and administering school lunch canteens. Activities are conducted at MCH facilities, Social Affairs Centers, and Cathwell facilities.

e. Maternal and Child Health

The Maternal and Child Health Program is directed by the Directorate of Public Health's Maternal and Child Health Division, and services are delivered through the over 300 MCH Centers. Services

offered by these Centers vary, but focus on those related to childbirth. The Centers also serve as sites for immunization, growth monitoring, and ORT information, and as gathering places for health education sessions.

f. Voluntary Family Planning

Togo's voluntary family planning program began in 1976 with the establishment of the private organization, Association Togolaise pour le Bien-Etre Familial (ATBEF). It began as a comprehensive MCH institution with services limited to pre- and post-natal care and dissemination of information about family planning -- contraceptive distribution was prohibited. It now has official permission to distribute contraceptives and is the leading private agency in the provision of voluntary family planning counseling and services. It operates its programs out of MCH Centers (administered by PNBEF, described below). It receives substantial support from the International Planned Parenthood Federation (IPPF) and will be a recipient of additional funds under an A.I.D.-financed project.

The GOT voluntary family planning program began in 1977 when the National Family Welfare Program (Program National du Bien-Etre Familial, or PNBEF) was created with the help of the United Nations Funds for Population Activities (UNFPA). The Maternal and Child Health Division of the Public Health Directorate is in charge of the program. Program activities so far have centered on educating the population about the dangers of closely spaced pregnancies and clandestine abortions (which are legally prohibited except for life-threatening situations). The program provides voluntary family planning services at MCH Centers in 10 of the 21 prefectures, and operates three clinics. Under it, 158 medical personnel have been trained in contraceptive methods and delivery of family planning services.

The private ATBEF and the public PNBEF cooperate, with ATBEF providing clinical equipment, contraceptive supplies, and staff training to GOT MCH Centers, and MCH centers providing premises for ATBEF service delivery.

Constraints to voluntary family planning are a wavering of public sentiment on family planning, a continuation by the GOT of the practice -- inconsistent with the National Family Welfare Program -- of providing financial benefits for the first six children of a family, a requirement that women furnish their husbands' consent before receiving modern contraceptives, and prerequisite laboratory tests for prospective contraceptive pill users: many women cannot afford these tests. Shortage of trained personnel, ignorance of family planning techniques, and lack of appreciation of the impact of high population growth rates on individual family welfare also are constraints. However, recent strong GOT interest in reducing the population growth rate is expected to result in a more liberal policy toward family planning.

g. Health Education

At the central level, the National Health Education Service (SNES), under the Division of Public Hygiene and Health Promotion,

conducts health education campaigns needed to support the GOT's health programs. At the request of personnel implementing a given program, it prepares and tests promotional and educational materials for mass media and for distribution to health facilities, schools, Public Health and Social Affairs workers, and their clients. At other levels, health education messages are transmitted through health and family planning facilities, Social Affairs Centers and their staff, through schoolteachers who have had some health training, and through Village Development Committees.

About 1983, SNES initiated efforts for a decentralized national health education program which would be fully operational by 1989. The underlying logic of these efforts was that an entity such as SNES charged with disseminating essential health information needed by the entire Togolese population should have a "field presence" which would facilitate its messages reaching the remotest regions. The decentralization program has three core thrusts: 1) establishment of a SNES office in each of the five Togolese regions; 2) formation and training of two-person Health Education Teams for each prefecture nominated by chief prefecture doctors from among their Public Health staff (each initially to be assisted by a U.S. Peace Corps Volunteer); and, basic training in health education for 1,000 public health field staff. UNICEF, Peace Corps, and CCCD have been the primary supporters of this SNES program so far. To date, two regional offices have been established, nine teams have undergone most of their basic training and are working in the field, seven teams are undergoing their basic training and are expected to be in the field by the end of 1987, individuals for the remaining five teams have been identified and will start training soon, and about 250 Public Health field staff have received the envisaged basic training. USAID/Togo preceives this SNES decentralization program as a promising development for enhancing the impact of MOH activities. The program will receive substantial project support in the areas of strengthening the Teams, conducting mass media campaigns, and designing appropriate graphics for use in rural areas.

h. Health Information System (HIS)

The health data gathering system in Togo has been judged by some to be the best in West Africa. In the past, unfortunately, data was sent to the National Statistical Office in the Ministry of Plan and rarely was processed in a timely manner, if at all. The last annual Health Report was prepared in 1981. Recently, it was agreed that health data would be first transmitted first to the MOH Sanitation Statistics Service in the Division of Epidemiology for processing to meet immediate health statistical needs, e.g., tracking of cases of communicable diseases. Then it would be forwarded to the National Statistical Office in Plan for the national data bank. The Sanitation Statistics Service has been equipped with data processing equipment in recent months.

2. A.I.D. Projects

A.I.D.'s previous investments in the health sector have been in primary health care, community infrastructure, GOT staff training, and family planning.

a. Rural Water Supply and Sanitation (RWSS) Project (693-0210)

This very successful project began in 1980 with the objectives of providing potable water, sanitation facilities and complementary health education to 245,000 rural poor in the Savanne and Plateaux regions. The project emphasizes training Social Affairs Agents and Sanitation Agents (from Public Health) and organization of Village Development Committees. It is due to end in December 1987. It has exceeded its objectives, having provided potable water (1,048 wells and 230 rainwater cisterns) and sanitation facilities (450 latrines) to about 650,000 rural inhabitants in about 800 villages, each with a Village Development Committee (VDC) organized under and used by the project. Ancillary benefits also have been provided, such as instruction in home preparation of an oral rehydration solution and in adult literacy using health education materials. About 72 Social Affairs Agents and about 48 Sanitation Agents have been trained and have at least three years' experience under the project. One of the important lessons demonstrated by this project's success is that the effectiveness of rural health service delivery is vastly enhanced by community participation and effective community organization, such as active VDCs. Accordingly, this Child Survival project will limit its most ambitious outreach activities to Plateaux and Savanne, focusing on the 800 organized villages. In order to capitalize on the VDCs, experienced Agents, and institutional linkages forged under the Water Supply project.

b. Togo Combatting Communicable Childhood Diseases (Togo/CCCD) 698-0421.02

This four year project began in 1983 and is expected to be extended until mid-1988. It has three components: 1) vaccination against diptheria, whooping cough, tetanus, measles, polio, and tuberculosis; 2) control of diarrhea through the use of ORT; and, 3) presumptive treatment of malaira. As such, it supports the GOT programs described above.

c. Previous Family Health Projects

Family Health activities have consisted of two closely integrated activities: (1) a bilateral grant, Family Health Project (693-0212), funded at $1.278 million, from 1977 through 1985; and (2) a centrally-funded project implemented by the Family Planning International Assistance (FPIA) PVO (Togo-02) from 1983 to 1986 at $221,771.

The bilateral funds financed construction and equipping of the Togo Family Health Training Center (FHTC) and related technical assistance. A core curriculum has been prepared, and a team of Togolese trainers has been trained in pedagogical methods. Theoretical and practical training courses in family planning have been held. The centrally-funded activity used the training center to train medical professionals and social workers. The bilateral project also furnished contraceptives and other commodities for 12 MCH Centers and supported provision of voluntary family planning services in 11 clinics located in the eight largest towns in Togo.

d. Togo Sub-project of the Family Health Initiatives II (FHI-II) Project, 698-0462.93

The $1.5 million three year project, obligated in April, 1987, incorporates the voluntary family planning elements which originally were envisioned to be part of this Child Survival project. The AID/W review of this Child Survival project's Project Identification Document (PID) recommended that family planning interventions be financed under FHI-II, primarily because of funding constraints. FHI-II has two distinct but mutually reinforcing sets of project activities: public sector, to be implemented through the MOH's PNBEF program; and, private sector, to be implemented by the ATBEF. Public sector activities will continue assistance previously provided to PNBEF under the above-mentioned Family Health Project. Funds are being provided for training activities to be carried out at the Family Health Training Center, service delivery, clinical equipment and supplies, and contraceptives. FHI-II also will continue the assistance to policy development activities currently provided under the centrally-funded RAPID project. Regarding the private ATBEF, FHI-II will improve the capability of ATBEF to support family planning services being provided through existing ATBEF and PNBEF facilities and rural outlets. Funds are being provided for an expanded Information, Education, and Communication (IEC) program, an outreach voluntary family planning program using motivators equipped with mobylectes, a rural distribution program that will operate out of rural dispensaries and through women's groups, a small laboratory at the ATBEF clinic, and training of ATBEF staff to improve specific skills and increase contraceptive management capacity. At the end of the project it is envisioned that family planning services will be provided at 23 MCH Centers, the four CHRs, and ATBEF, that all will be fully staffed and equipped, and that there will be 36,000 family planning acceptors.

H. OTHER DONORS

A table of other donors' Child Survival-related activities in included at Annex M.

1. UN Agencies

This table shows that UNICEF has been the most vigorous supporter of Child Survival. engaging in vaccination campaigns, diarrheal disease control through ORT, nutrition, MCH, health education, malaria treatment, and endemic disease control. UNICEF can be expected to provide Child Survival programming leadership in the future as well. UNICEF's announced program objectives are:

-- To increase public awareness regarding the need for immunizations and achieve 80 percent coverage by 1990;

-- To train all nurses, midwives, and itinerant health agents in the principles and practices of EPI;

-- To establish 150 additional fixed vaccination sites in existing health facilities for a total of 350 fixed vaccination sites;

-- To promote growth monitoring and the well-baby clinic concept as part of the MCH program, and to work with Catholic Relief Services on its supplementary feeding, nutrition, and child health care program; and,

-- To assist in promoting public health education programs through prefecture-level health service delivery facilities.

The World Health Organization also has been active in vaccination, nutrition, MCH, malaria treatment, and water and sanitation. In Lome it maintains a training center for training health personnel from Togo and other African nations.

2. World Bank

The World Bank is scheduled to embark on an ambitious health sector effort in June, 1987, which will have major impact throughout the sector, including on Child Survival activities. The 1987 six month preparatory phase is budgeted at $380,000. It is envisioned that the implementation phase, scheduled to begin in July 1988, will cost nearly $10 million. An overview of this project's activities includes:.

-- strengthening of health services through:
. rehabilitation of selected health facilities;
. training;
. strengthening the system of providing essential drugs; and,
. study of recurrent costs.

-- institutional strengthening through:
. MOH reorganization, notably establishment of a ministerial-level planning and budget preparation unit to deal with all MOH activities, and decentralization of the public health function by creation of a Regional Directorate of Public Health in each region; and,
. health data collection and analysis, and systematization of information feedback.

-- health education and training.
-- National Population Planning Policy development, focusing on analysis of demographic variables for development planning.

The preparation phase involves the establishment of a Project Preparation Unit to manage project design and refinement efforts. It may be the precursor of the envisioned Planning Unit.

3. FED

The FED has been notably active in the health sector as an early leader in providing potable water sources through large scale well drilling and pump programs. Little effort was made to involve communities in the maintenance of the furnished pumps and the FED program has suffered from a high percentage of inoperable pumps due to a lack of a systematic maintenance program.

In 1986, the FED began a pilot project to develop a three-tiered system of pump repair in the regions of Kara and Centrale. This system consists of village pump maintenance committees, private sector itinerant pump repair persons, and GOT technicians to undertake more complex repairs. The FED is seeking additional funding to extend this pilot into a long-term national program of pump maintenance and repairs.

The FED is also very interested in incorporating family planning activitis into its programs.

4. Bilateral Donors

West Germany has been active in supporting Togo's health sector since 1960. Until recently it had a guinea worm control project in the North. For some years it has funded a surgeon and a gynecologist for the CHU. They have been active in building health facilities such as an orthopedic center and a maternity clinic. The German Protestant Church, in cooperation with a Togolese analogue, runs a general hospital. The West German Embassy has a modest allotment for use in micro-projects which are implemented by missionaries. In 1985-86, the West Germans contributed to a potable water project. They now plan to integrate a basic health program into their current economic development efforts.

The French AID and Cooperation (FAC) service has subsidized equipment for three health centers, built two similar centers, contributed to potable water projects (notably providing pump sets and financing their installation for the A.I.D. water supply project), and participated in the GOT vaccination program.

The Danish (DANIDA) have focused their efforts on potable water systems for major cities and carried out research on water projects.

The Canadians are engaged in a village potable water and health services project similar in concept to the A.I.D. water supply project. This project has begun a pilot pump repair program modeled upon the FED program described above. It is operating in two prefectures of the Maritime region.

5. PVOs

a. Catholic Relief Services: Cathwell

The Togo unit of Catholic Relief Services, Cathwell, manages a PL 480, Title II, program which focuses on infant and child nutrition and growth monitoring, with accompanying client health education and staff training. Its five-year Operational Plan calls for increased programming in improved weaning practices and developing weaning foods. Its school feeding program is expected to be used as an entry point for health education.

b. Others

The Baptists implement a well drilling, pump installation, and health education project in the remote northeast section of the Plateaux region. World Neighbors is active in family planning in its health services system in several regions. Meals for Millions is active in health education in the northern part of the Savanne region.

II. DETAILED PROJECT DESCRIPTION

A. RATIONALE AND CONCEPTUAL FRAMEWORK

1. Problem and Rationale

In Togo, one infant out of ten does not live to see its first birthday; three children in ten do not live to see their fifth birthday. Children who survive initial years of fighting debilitative illnesses are weaker than those nurtured in more favorable conditions, and ultimately are less productive members of society. Another negative consequence of high infant and child mortality rates is a high birth rate, accruing in part from attempts to assure an "adequate" number of surviving offspring. Although tremendous strides have been made in the past century in conquering or lessening the severity of the diseases which are responsible for most of these infant and child deaths, Togo's health statistics reflect little improvement. The problem this project addresses is Togo's very high infant, child, and maternal mortality rates, which today are unnecessary because their causes are preventable.

Togo's dismal health statistics result from a variety of factors. For example,

-- only 15 percent of rural births take place in sanitary conditions;

-- in 1984, immunization coverage of infants was unacceptably low, e.g., polio - 34 percent, diptheria - 25 percent, measles - 11 percent, whooping cough - 5 percent;

-- in 1983, ORT was rarely used to prevent diarrheal dehydration, and increased use of the technique has been slow; and,

-- health services, including those for relatively simple, inexpensive preventive health care, do not reach the great majority of the rural population, even though 60 percent of the population is within walking distance of a health service center.

GOT officials responsible for the health sector generally acknowledge these conditions as the causes of Togo's unfavorable health profile. To confront the situation, they have adopted policies which reflect a shift in emphasis to preventive from curative health care. However, in establishing programs to implement these policies, even the most vigorous, enthusiastic officials are stymied by diminishing material and human resources. This paucity of resources is exacerbated by waste and duplication of effort accruing from absence of systematic planning, coordination, monitoring, and evaluation of health programs. As a result, existing service delivery is inadequate.

The rural Togolese population, for its part, is caught in a double bind of its own unawareness of easy preventive health interventions it can seek and take on its own behalf, and of the GOT's lack of resources and expertise needed to provide effective community health services. Effective services (which include health education) of themselves will create a village-level awareness of and desire for

preventive health interventions, and their benefits. It is only very recently that the GOT has begun mass informative educational campaigns to persuade the rural population that the state of its health is in its own hands to a much greater extent than it realizes.

To break this bind and to improve rural health service delivery, the GOT is focusing on high priority Child Survival interventions as a first step to offering the full panoply of preventive health care services. Specifically, the high priority interventions center on vaccination, ORT, and malaria treatment, which are conspicuous for yielding dramatic improvements in mortality and morbidity rates, while requiring only a modest monetary investment. These interventions involve easily applicable techniques of proven effectiveness in rural areas. Adding to the rationale for adopting this focus is the prolonged and multi-dimensional nature of the benefits realized: today's infant and child beneficiaries who survive and are strong also will be tomorrow's beneficiaries as resilient, productive youths and adults -- a result which positively affects all aspects of Togolese society and activity. In light of the humanitarian and economic imperative confronting the GOT to improve its people's health status, a cluster of Child Survival interventions of proven effectiveness, requiring relatively modest monetary outlays, and predictably yielding long-term, wide-range benefits is a logical place to start.

Critical efforts to launch and sustain a durable Child Survival program require investment in:

-- Public Health personnel training in communications skills, in the elements of a comprehensive Child Survival Program and their coordinated administration, and in Child Survival service delivery;

-- instructional materials;

-- medical commodities for health interventions;

-- logistic capability to transport personnel and appropriate medical and educational equipment to rural Health Centers and to village communities;

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

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

Togo's current fiscal plight makes these investments beyond its reach. It needs help from the donor community. To the extent that this help has been forthcoming from A.I.D., CCCD, UNICEF, WHO, CRS and others, it has been fragmented, and sometimes duplicative.

The GOT has not yet conceived a Child Survival Policy and Strategy Statement which would guide allocation of resources for Child Survival activities for optimal beneficial impact and rank service delivery on an assessment of need. Such a policy, strategy, and needs prioritization, and the planning, budgeting, and coordination capacity to implement them, are indispensable if the GOT and donor resources -- all of which are scarce -- are to be invested for maximum Child Survival benefit.

This project is designed to respond to the GOT's need to develop a Child Survival Program structure and associated planning and managerial capacity. It also is designed to orient Health Center personnel toward the communities they serve, and to raise villager awareness of Child Survival measures. As such, the project is designed to provide essential prerequisites for an effective, cohesive, self-sustaining Child Survival promotion and service delivery endeavor. At the end of the project, the MOH will be on a solid footing to continue Child Survival efforts, to extend the reach of its services to rural areas throughout the nation, to expand the range of its services to the full complement of primary health care, and to make significant headway in reducing the rates of infant and child mortality and morbidity.

2. Project Goal, Concept, and Purpose

The overall goal to which this project contributes is an improvement of the health status of the rural Togolese population.

The project purpose is to assist the GOT to plan, manage, and coordinate the delivery of Child Survival services in a rational, cost-effective way. This purpose will be achieved after four years of implementing activities organized into three components.

The first, the Child Survival Planning and Coordination component, establishes and supports a Child Survival Planning and Coordination Unit which will introduce a standardized, nationwide Child Survival planning and budget exercise designed to optimize the beneficial impact derived from the scarce resources available for Child Survival activities. The second component, the Health Centers Support Component, focuses on Public Health staff working at Health Centers, instructing them in effective interpersonal approaches and adult health education techniques for use with their clients, and in the substance, efficacy, and promotion of Child Survival measures. The third component, the Outreach Network Component, in addition to the second component's instruction of Public Health personnel, undertakes village outreach activities in the Plateaux and Savanne regions where organizational linkages and villager commitment to community development tend to be more advanced and productive than in other regions, due largely to the head start given these areas by participation in RWSS Project activities. The second and third components support the first by fostering the conditions which a comprehensive, cohesive, well-planned, and prudently-budgeted Child Survival Program requires for successful implementation.

Expatriate long-term technical assistance personnel will consist of a Senior Advisor/Health Planner, an Information-Education-Communications (IEC) Specialist (both under contract with a U.S. firm), and an Agents' Coordinator (under a personal Services Contract). Key GOT personnel involved in project implementation will be the Child Survival Unit Director, two senior MOH officials seconded to the Planning and Coordination Unit to serve as Unit Coordinators, 42 Prefecture Health Education Team members drawn from the ranks of Public Health personnel, and about 120 Community Agents of which about 72 originally were Social Affairs field workers and about 48 were Public Health Sanitation Division field workers. There also will be a Togolese Teams' Coordinator working under a Personal Services Contract and serving the counterpart to the Agents' Coordinator. These personnel will be supplemented by resources provided pursuant to Collaborative Protocols with GOT entities, donors, and PVOs having training skills and technical expertise to contribute to project activities. This combination of individuals and resources will assure component coordination, timely project implementation, and high technical standards.

3. Project Zone

This project is national in scope. Planning and coordination activities and support of Health Centers will be undertaken in all 21 prefectures. Outreach efforts, however, are limited at this point to Plateaux and Savanne because only in these regions do sufficiently strong organizational linkages currently exist due to the success of activities under the RWSS Project.

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A detailed description of each component's activities, inputs, and anticipated outputs follows.

B. COMPONENTS

1. Planning and Coordination Component

The economic plight of the MOH makes it essential that the Ministry husband its increasingly scarce resources for maximum benefit. Yet there is significant fragmentation, waste, and duplication of effort accruing in large part from a lack of planning, budgeting, and coordinating capacity within the Ministry, and from the absence of MOH personnel qualified in these specialties. There is need for a central reference point to clarify priorities and assure an efficient division of labor for the eight Public Health Divisions, and for a clearinghouse to bring about cost-effective collaboration among the three directorates and to prevent their duplicating each other's activities. Regarding Child Survival, there is need for an officially promulgated document articulating policy, program composition, and strategy, so that MOH priorities, rather than donor and PVO enthusiasms, determine resource allocation.

a. Component Activities and Operation

Activities pursuant to this component are designed to help overcome these shortcomings. A Child Survival Planning and Coordination Unit (the Unit) will be formed within the MOH and will report directly to the Minister. It will be headed by a Togolese Director with training and extensive experience in planning, budgeting, and public administration. It is foreseeable that the Director will be seconded from the Ministry of Plan for the project's duration. The Unit also will be staffed by two MOH officials (Unit Coordinators), ideally one from the Directorate of Public Health and one from the Directorate of Social Affairs. These MOH Coordinators will acquire planning, budgeting, and public administration skills during the project which they will continue to use after the project's termination to increase the MOH's effectiveness and service delivery capacity.

The Unit will be guided by a Child Survival Advisory Board (the Board), which will meet at least twice a quarter, composed of the three MOH Directors General. The Minister will appoint the Board's Chairman. The Unit also will be assisted by a National Child Survival Commission (the Commission), a working group composed of operational-level representatives from all entities and organizations interested in and participating in Child Survival efforts, e.g., the MOH, GOT Ministries such as Plan, Rural Development, Hydraulics, and Finance, donors, PVOs, and religious organizations. The Commission also will meet at least twice a quarter to orchestrate effective collaboration among participants, facilitate exchange of information and experiences, prevent duplication of effort, encourage accord on priorities, solicit new funds for Child Survival, and assure resource allocation for priority uses. The Minister will designate the Commission's President. The Unit will make use of the Commission by soliciting its constituent agencies for cooperation with project activities.

The Unit's major initial effort will be the conceptualization and drafting of a ten year National Child Survival Policy and Strategy Paper to identify priorities and chart action. Simultaneously it will embark on its most demanding sustained task, the establishment and institutionalization of a planning and budgeting exercise which will involve a wide spectrum of MOH personnel, from the Minister and other key officials at the central level to chief doctors and other staff at the prefecture level. This exercise, to be performed annually, will produce five year plans and budgets which cover the first three years in operational detail and discuss the following two years in terms of programmatic emphases and budgetary order-of-magnitude estimates. Early in the project, long-term technical assistance personnel assigned to the Unit will prepare training materials, reference manuals, procedural instructions, standardized forms, and cost indices. These personnel and the Unit Director will conduct a series of training sessions in the principles and execution of planning and budgeting for all MOH personnel who will participate in the annual preparation of the plan and budget. The functioning of this process is described in the Technical Analysis.

As the entity charged with coordination of Child Survival efforts, the Unit will assume primary day-to-day responsibility for enlisting collaboration and constant interchange among agencies active in supporting Child Survival. This responsibility will be demanding because it entails continual monitoring to assure that the various agencies' interventions are productively integrated for optimal impact. The responsibility also includes undertaking the preliminary arrangements for and execution of numerous Collaborative Protocols pursuant to which MOH entities and other organizations will contribute their expertise and coordinate their respective Child Survival efforts with this project's implementation. These Protocols will be critical for enlisting qualified assistance to conduct the pedagogical and technical instruction envisioned under the other two components.

The Unit, as such, may or may not survive this project. It is the process of planning, budgeting, and coordination which must be sustained after the project, and there is good reason to expect that these functions and processes will continue. They will have demonstrated their effectiveness for improving MOH operations during the project, and MOH officials should be interested in continuing to improve effectiveness. Also, relevant MOH personnel will have been trained in correct implementation of these functions and processes, and will be able to continue their implementation. Post-project planning, budgeting, and coordination can continue in one of several ways. The functions can be included in the standard operating procedures of the MOH, and appropriate, sufficient personnel assigned for implementation, whether or not they are part of a specialized entity, such as the Unit. Another possibility is for the project's Unit personnel, especially the two MOH Coordinators, and the processes used during the project, to be transferred to the planning entity to be established under the World Bank

sponsored health sector reorganization - decentralization endeavor. Arguably, this would be the optimal solution for continuing the project-initiated planning, budgeting, and coordination processes because there predictably would be opportunity to amplify the scope and impact of these processes throughout the health sector under the World Bank program.

b. Inputs

Project inputs provided to help the Unit, the Board, and the Commission get off to an effective start include financing of the Togolese Director's salary, long- and short-term technical advisors, commodities, vehicles, and operational and training support costs. Regarding long-term technical assistance, a Health Planner who will act

as Senior Advisor to the Unit, and an Information-Education-Communications (IEC) Specialist each will serve for three years. Both will have health training backgrounds. The IEC Specialist must have experience covering mass media campaign conduct, training material preparation, and instructional and reference material design and distribution. This Specialist also must be skilled in preparing promotional and educational materials for illiterate audiences. Limited short-term technical assistance will be provided on an ad hoc basis. Financing for up to two U.S. Masters degrees in public health planning and administration and up to two in-country management seminars given by personnel from a U.S. university specializing in such seminars has been budgeted.

Premises with sufficient space for a modest conference room will be rented for the Unit, and office equipment (including two computers and appropriate software) and supplies will be procured. The project will finance a Unit motorpool of two sedans and one four-wheel-drive utility vehicle, and associated petrol, oil, lubricants, and maintenance. Project-financed expenses incurred in training MOH officials to execute the above-mentioned planning and budget exercise include costs of training aides and take-home reference materials, conference facility rent, participant transport costs, and per diem for instances in which overnight absence from one's home base is required.

c. Outputs

Outputs which will accrue from the above-described inputs and activities include:

-- a ten year National Child Survival Policy and Strategy Paper prepared under Unit auspices;

-- an implemented model MOH annual planning and budgeting exercise for at least Child Survival activities;

-- an Inventory of ongoing and proposed Child Survival activities in Togo prepared by the Unit, with substantial effort and information contributed by the Commission -- the purpose of the Inventory being to facilitate a "mapping" of Child Survival efforts and an informed determination of greatest need for subsequent interventions;

-- an eight year Child Survival Training Plan and Budget prepared under the Unit's direction with the help of short-term technical assistance;

-- up to two U.S. Masters degrees in public health planning and administration;

-- up to two in-country management seminars for up to fifty people each by or similar to those conducted by the University of Pittsburgh;

-- a study of recurrent costs and sustainability of Child Survival activities prepared under the Unit's direction;

-- myriad training and reference materials on planning and budgeting which, once mastered in the Child Survival context, can be applied to any MOH enterprise to improve management and maximize resource use;

-- inclusion of Child Survival subjects in curricula of institutes training medical personnel as a result of Unit and Commission collaboration with the institutes; and,

-- Project Collaborative Protocols between the Unit and GOT entities and/or other organizations whose pedagogical and/or technical services will be contributed to and deliberately coordinated with this project's implementation.

2. Health Centers Support Component

For project-sponsored Child Survival planning and budgeting activities to be more than an empty and expensive exercise, there must be systematized liaisons between those supplying Child Survival services and those in need of -- and, ideally, demanding -- those services. The primary health service providers in rural Togo are Public Health staff stationed at Health Centers. These personnel must create an inviting, comfortable ambiance which will make villagers within their purview want to visit the Centers and avail themselves of health education and other services. They must be familiar with the constituent parts of the Child Survival program and their interrelationships, and skilled in communicating this information to often illiterate audiences. They also must be qualified in and equipped for Child Survival service delivery, and be acquainted with central, regional, and prefecture level MOH entities and other organizations with which they can coordinate to supplement their own resources and expertise.

The segment of the Togolese population most in need of Child Survival services is the village family with children up to the age of five. They must know what the main Child Survival measures and their benefits are, which measures can be administered in the home, and where the complete range of services can be obtained. Beyond being informed in these areas, Togolese village families must be motivated to adopt behavioral changes, readily and correctly administering those Child Survival measures which can be used in the home, and availing themselves of Child Survival services at health facilities within reasonable proximity of their residences.

At this time none of these conditions exist to a sufficient extent for a Child Survival program, however well planned on paper, to have a reasonable chance of success in reality. Contributing evidence for this assertion is the estimate that, although 60 percent of the rural population lives within easy walking distance of a health facility which offers vaccination services, only half of the target beneficiary population gets vaccinated.

This component responds to the need for establishing a systematized liaison between Public Health personnel and village families. Because this project cannot itself attempt to reach all the rural-based Public Health personnel and villagers in Togo, it adopts a "training-of-trainers" approach, relying heavily for trainers on the Prefecture Health Education Teams which are part of the SNES decentralization program mentioned earlier in the Background Section.

a. Teams' Origins, Composition, Qualifications, MOH Initial Basic Training, and Current Activities

Teams are composed of two Public Health personnel (a "Coordinator" and an "Assistant Coordinator") nominated by the Chief Doctor in their respective prefectures and concurred in by SNES. During their initial years, each team will be aided by a Peace Corps Volunteer who, after preparatory Peace Corps training, participates in the Team members' SNES-organized training. The formation of Teams began in 1985 with a group of nine Teams. These teams now are working in their assigned prefectures. A second group of seven Teams and Peace Corps Volunteers will begin their SNES training and field work in October, 1987. A third group of five Teams and Volunteers will be in place about October, 1988. By early 1989 there should be one Team operating under SNES auspices in every prefecture.

Team members have impressive and appropriate credentials for the kind of field work they undertake. Fourteen of the eighteen already in place have high school degrees; the other four have junior high degrees. Before their selection as Team members, they served as Superior Public Health Technicians, Sanitation Agents, Hygiene Assistants, nurses, and Medical Assistants (nurses with supplementary training). Their qualifications and experience equip them well to benefit from technical training in Child Survival techniques and to be taken seriously by Public Health personnel with whom they will be assigned to work.

SNES-sponsored training for the Teams has received assistance from UNICEF and the Peace Corps. It is designed to prepare Teams for instructing Health Center-based Public Health personnel in interpersonal skills, adult health education techniques, and technical subjects, and also for village level community mobilization and health education. There is a special gloss on promoting Child Survival in rural areas where, for example, mothers need to be prepared for the fact that a child may be feverish after a vaccination they understood would prevent fever. Team training emphasizes special approaches for presenting health information to often ignorant or suspicious villagers. Among the topics covered in Teams' training are: audio visual aid use; practice surveys; adult health education techniques; design and implementation of health activities; coordination of health activities; coordination of health activities with others' health-related efforts; and, the three core Child Survival areas of vaccination, ORT, and malaria treatment.

So far Team activities have focused on working with Public Health personnel in helping these personnel to improve their client and community relations and to upgrade their adult health education skills. Teams also have been persuading these personnel of the efficacy of Child Survival measures which some staff heretofore have regarded with a mixture of skepticism and cynicism in spite of their medical training. As a result, Public Health staff who have benefitted from the Team's instruction are becoming informed, enthusiastic promoters of Child Survival measures. In addition, the Teams have engaged in village community mobilization and education. For example, having convinced villagers of the desirability of vaccination, Teams have guided organized solicitation for a fund to maintain a kerosene refrigerator so that that village can participate in the cold chain. Teams also have put on

educational skits in villages to promote Child Survival measures. Ultimately it is envisioned that coordinated planning for local level health activity will become an important Team enterprise so that health experts, instructors, and service delivery personnel in a given area contribute to and enhance, rather than duplicate or impede, each other's efforts. This local coordination role will lead to consistency of health messages and optimize resource use.

b. Teams' Role in this Project

The Teams will serve as Trainers of Trainers for this project, and the project-sponsored instruction they undertake will be exclusively for Public health staff of local Health Centers: village-level Team efforts will remain the domain of SNES (perhaps with UNICEF, CCCD, and Peace Corps assistance). As a result of Team instruction, Public Health personnel will strengthen their skills in educating villager clients about Child Survival -- both home measures and services offered by Centers. Health staff also will learn procedures for routine follow-up of villagers to assure that villagers are becoming convinced they need and are using Child Survival services. Accordingly, the systematized liaison between service providers and service beneficiaries necessary to a successful Child Survival Program reasonably can be expected to develop.

When this project begins, then-active Team members already will have been trained in the subjects in which they will receive reinforcement training under the project, and they already will be active in the kind of instruction of Public Health personnel they will undertake for the project. As such, this project's interventions to assist the Teams will enhance their skills and effectiveness, and will support SNES' sensible concept of decentralizing health education administration. The fact that this component supports an ongoing activity to which the MOH is committed, as opposed to superimposing a new, unknown enterprise on MOH programs, bodes well for implementation success.

c. Component Activities and Operation

This component trains Team members to be trainers of Health Center-based public Health personnel, who in turn will instruct village clients. The IEC Specialist will be the lead instructor for Teams' training in interpersonal and community relations skills and in basic adult health education and promotional techniques. The Health Planner will be the lead trainer in how to plan and implement local health activities in a coordinated way so as to maximize the beneficial impact of each participant's endeavor, and so as to synergize the benefits of their combined efforts. This component's training will focus on these two areas. They are considered sufficiently needed and important in themselves to warrant undertaking this component even were there no additional training contemplated. However, supplementary and complementary training will be provided through Collaborative Protocols with MOH entities and other organizations in the rudiments, rationale, and efficacy of Child Survival practices, and in the technical fundamentals of vaccination, ORT, presumptive malaria treatment, nutritional surveillance/growth monitoring, and voluntary family planning -- with hands-on, demonstration-cum-practice sessions for those measures which can be administered in the home. The above-described training with

refresher sessions will be an on-going effort given at least six times a year throughout the project, rather than provided in a concentrated period early on.

Team members, using project-financed motorcycles, will visit the Health Centers in their prefectures at least once a month and instruct the Public Health personnel in the communications techniques and Child Survival measures in which they have been taught. Team members will monitor the progress of their assigned Centers, and will assist Center personnel in following through on their client villagers. In this way the correctness of villager understanding and use of Child Survival techniques can be determined, and remedial measures taken when necessary.

A Togolese Teams' Assistant serving under a Personal Services Contract will coordinate the administrative operations of this component. He or she will aid Team members in obtaining the resources they need to execute their project-related responsibilities, make the administrative arrangements for Teams' training, and serve as project liaison among Teams, the A.I.D. Mission, the Unit, SNES headquarters, MOH entities, and other participating organizations.

d. Inputs

Project-financed inputs pursuant to the Health Centers Support Component are:

-- motorcycles, spare parts, petrol, oil, lubricants, and funds for motorcycle repair;

-- operational costs (transport, per diem, lunch money for Team members) of training by the Teams' Assistant and the IEC Specialist in communications skills for enhanced interpersonal and community relations, and in adult health education techniques during at least 15 one-day sessions per Team during the project;

-- operational costs of training by the Health Planner in local level coordinated planning and implementation of health activities during at least 15 one-day sessions per Team during the project;

-- salary and necessary support costs for a Togolese Teams' Assistant, a private citizen who will organize, monitor, coordinate, and otherwise facilitate Teams' project-related activities;

-- a project motorpool vehicle (and associated petrol, oil, lubricants, and repair costs) assigned to facilitate this component's activities;

-- teaching materials, IEC materials, audio-visual aids, and demonstration packets;

-- operational costs of training given pursuant to Collaborative Protocols to the extent these costs are not borne by the collaborating entity; and,

-- construction materials and services for two modest Child Survival demonstration centers.

Project-facilitated inputs, such as technical and pedagogical expertise and resources from MOH entities and other organizations (CCCD, UNICEF, WHO, PVOs, and religious groups), will be made available pursuant to detailed, activity-specific Collaborative Protocols with the Unit. These inputs will be especially important in upgrading the Teams' technical knowledge and skills related to vaccination, ORT, and malaria treatment.

e. Outputs

Significant outputs anticipated from the Health Centers Support Component include:

-- mobility of 21 Teams;

-- 21 Prefecture Health Education Teams trained and experienced in: 1) effective interpersonal approaches; 2) general adult health education techniques; 3) coordinated planning and implementation of health activities; 4) promoting and instructing in the substantive rudiments, underlying rationales, and efficacy of key Child Survival measures (vaccination, ORT, malaria treatment, nutritional surveillance/growth monitoring, and voluntary family planning); and, 5) demonstrating and applying home-administered Child Survival measures (ORT, presumptive malaria treatment, and Guinea worm prevention);

-- about 1,300 Team-instructed Health Center-based Public Health staff in same subjects (except for activity planning) as Teams' training;

-- uniform, correlated instructional curricula, manuals, audio-visual aids, demonstration packets, and reference materials for Teams' training by the IEC Specialist and cooperating instructors, and for Teams' subsequent use in working with and for distribution to Public Health staff;

-- consistent, correlated IEC materials for distribution to villagers on Child Survival topics; and,

-- two modest Child Survival demonstration centers.

3. Outreach Network Component

a. Background

Project-financed activities under this component will supplement and complement those under the Health Centers Support Component by reaching beyond Public Health personnel to work with villagers, and, with the help of various field workers, will forge a network which integrates villagers with Health Centers. These activities will be undertaken only in Plateaux and Savanne regions, where prior interventions of the RWSS project already have established fully operational village development committees (VDCs), a trained cadre of village level workers or Community Agents, and the rudimentary outlines upon which to build an outreach

network. Prudence dictates that project-sponsored village outreach be undertaken only where essential preliminary community mobilization has been satisfactorily completed. It is imperative to move cautiously and select population clusters which have shown themselves to be willing, quick learners and effective, committed users of new information and techniques because experience in similar development contexts indicates that Child Survival village outreach is beset with difficulties of follow-up and risks of misunderstanding health messages, misapplication of taught techniques (with perhaps harmful consequences), and waning enthusiasm of village populations. If village outreach is pursued haphazardly, it may produce unsuccessful, ridiculous, or harmful results -- or any combination of the three. In such instances, "Child Survival" acquires a negative image and communities shun associated interventions. Accordingly, an overextended, carelessly flamboyant village outreach effort can do Child Survival propagation more harm than good. However, if Child Survival village outreach is pursued in predictably fortuitous circumstances, there is a good chance for its success, and consequent attractiveness and dissemination to other communities which want Child Survival benefits for their offspring. Therefore, this project will focus on two regions with proven village self-help and development track records.

b. Component Activities and Operation

The means of reaching villagers with community mobilization strengthening and Child Survival health education will be Community Agents -- about 72 Social Affairs and 48 Sanitation field workers with at least five years' community organization and education experience under the RWSS Project. These Agents will continue working with the 800 VDCs representing 650,000 people that comprised the target beneficiaries of that project. Their project-financed activities will be organized, monitored, coordinated, and otherwise facilitated by an expatriate Agents' Assistant serving under a Personal Services Contract. The Agents will receive refresher training in community mobilization and health education techniques from the Agents' Assistant and the IEC Specialist. They also will be trained in Child Survival theoretical principles and practical precautions, techniques, and self-help measures suited to rural home implementation pursuant to Collaborative Protocols between the Unit and MOH entities and other organizations. Through the efforts of the Agents' Assistant and selected Team members, the Agents will be introduced to other local personnel active in Child Survival who will participate in the outreach network and serve as resources for Agents' village-based activities. Such personnel include chief prefecture doctors, prefecture Health Education Teams, Public Health staff based at Health Centers in the Agents' vicinity, and representatives from donor, PVO, and religious organizations active in the area.

Agents will visit their assigned villages at regular intervals to motivate VDCs, instruct in Child Survival principles, assist in identifying and prioritizing Child Survival problems, transmit appropriate Child Survival techniques, monitor progress, and uncover constraints. Agents will promote village self-help measures, such as collection of money to finance maintenance of a kerosene refrigerator and transport of Public Health workers to the village to give vaccinations -- or, in the alternative -- public or local taxi transport of villagers to

health facilities for vaccination and other Child Survival services. Agents also will organize Child Survival Field Days for groups of villages at a convenient central location. Detailed instruction and practice sessions on selected Child Survival topics will be provided during these Field Days, and other actors in the outreach network will be called on to participate. In all their Child Survival health education endeavors, the Agents will employ instructional aids and distribute take-home materials prepared under the auspices of the IEC Specialist coordinating with SNES, or produced by other organizations and contributed pursuant to Collaborative Protocols.

In addition to the facilitating oversight provided by the Agents' Assistant, this component's activities will be supervised by the Unit Coordinator from Social Affairs who will have a direct chain of command through the chief regional Social Affairs officer to the chief prefecture Social Affairs officer. Implementation responsibility will be divided between the Coordinator and the Assistant along the lines of the Coordinator ultimately authorizing a proposed activity or expenditure, or approving a voucher, and the Assistant orchestrating implementation of the activity and monitoring voucher preparation. Two Togolese Accountants, one for each region, will attend to record keeping and executing financial procedures in accordance with A.I.D. requirements.

c. Inputs

Project-financed inputs for the Outreach Network Component are:

-- motorcycles, spare parts, petrol, oil, and lubricants, and funds for motorcycle repair;

-- financing of a Personal Services Contract for the Agents' Assistant;

-- a project motorpool vehicle (and associated petrol, oil, lubricants, and repair costs) assigned to facilitate this component's activities;

-- operational costs (Agents' transport, per diem, lunch money) of refresher training in community mobilization and communications by the Agents' Assistant and the IEC Specialist -- at least five sessions per year;

-- operational costs (transport and lunch money) of Child Survival Field Days;

-- teaching materials, IEC materials, audio-visual aids, and demonstration packets;

-- operational costs of training given pursuant to Collaborative Protocols to the extent these costs are not borne by the collaborating entity; and,

-- salaries of the Plateaux and Savanne regional accountants.

Project-facilitated inputs, such as technical and pedagogical expertise and resources from MOH entities and other organizations, will be made available pursuant to detailed, activity-specific Collaborative Protocols with the Unit. These inputs will be especially important in providing technical instruction on Child Survival measures to Agents.

d. Outputs

Significant outputs anticipated from the Outreach Network Component include:

-- mobility of Community Agents;

-- 120 Community Agents upgraded in community mobilization skills and trained in Child Survival-related village outreach;

-- at least 480 village-level Child Survival Field Days covering at least Child Survival in general and vaccination, ORT, and malaria in particular; and,

-- uniform, correlated instructional curricula, manuals, audio-visual aids, and demonstration and reference materials for use in Agents' training, and for Agents' distribution to client villages.

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Inputs not easily attributable to one component include:

-- Health Planner and IEC Specialist assistance;

-- the salaries of the national Accountant and Assistant National Accountant, both to be based at the Unit headquarters;

-- support staff salaries for: 1) a bilingual secretary; 2) a receptionist; 3) a financial/administrative assistant to manage the technical assistance contract; 4) chauffeurs; 5) plantons; and, 6) guards;

-- funding for locally-available services to perform Knowledge, Attitudes, and Practice (KAP) Surveys;

-- funding for mass media and IEC endeavors; and,

-- funding for evaluations and audit.

Outputs not easily attributable to one component include:

-- Collaborative Protocols; and,

-- the above indicated KAP Surveys, mass media and IEC endeavors, evaluations, and audit.

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Having described what this project is, it is equally necessary to specify what it is not. First, this project is not a service delivery project. It will upgrade service delivery by strengthening communications and Child Survival-related skills of Public Health personnel, but the project itself finances no service delivery. Second, although the project unquestionably is a human resources enhancement endeavor, it is not a prototypical training project. In general, Team members and Agents who will be trained and who will serve under this project are not acquiring new skills which will equip them to earn a living, nor to earn a better living in monetary terms. Rather they are acquiring and upgrading skills which will enable them to increase their professional impact and their contributions to society. In today's Togo, the latter emphasis is more appropriate and helpful than the former: indeed, it is critical.

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The payment of per diem and transport costs to GOT personnel receiving training under this project necessitates a clarifying explanation in light of A.I.D. policy against paying salary supplements to host government employees. The per diem and transport payments to GOT personnel under this project have been designated for MOH officials undergoing planning and budgeting training, and for the 42 Prefecture Health Team Members and the 120 Community Agents participating in adult health education and Child Survival training. Without project-financed per diem and transport payments, these personnel could not participate in the training because the GOT has indicated it cannot finance these modest expenses. Without the training, the project purpose could not be achieved. Accordingly, the project has included funding these costs as operating expenses of undertaking in-country training. These payments are not considered to supplement the salaries of the recepients, but rather to make possible an essential project activity. In order to assure that recipients are not receiving duplicate per diem and transport allowances, each will be required to sign a written certification that he or she has not, and will not, receive a similar payment from the GOT or from other sources.

For itemized budgetary information concerning project inputs, see the Financial Plan herein. A vehicle waiver is set forth in Annex F.

Additional information on the relationships among the goal, purpose, outputs, and inputs of this project is provided in the logical Framework at Annex E.

Information on the practical implementation of this project is provided in the Implementation Plan.

C. RESULTS

At the end of this project MOH priorities, rather than donor preferences, will determine investments in Child Survival. The recommendations forthcoming from the planning and budgeting process will strengthen the MOH's claim to a larger share of GOT resources, and the information accruing from this process will be statistically-supported, well-reasoned ammunition for the the MOH to use in soliciting resources from the donor, PVO, and religious communities. The MOH planning and budgeting process and its enhanced coordination capacity, the strengthened Health Center staff, and demonstration outreach networks in two regions will work together to maximize the beneficial impact of the limited resources available for allocation to Child Survival.

The Teams element of the SNES decentralization program will be solidly established and health education dissemination will be improved. As a result, a large proportion of Togolese villagers will have been introduced to Child Survival, able to administer simple techniques in their homes, and increasingly willing to expend extra effort and/or money

to obtain some of the more sophisticated services. These combined results will lay the groundwork for nationwide provision of the full range of preventive primary health care and "well-baby clinic" services which will have a dramatic beneficial impact on the health status of Togo's rural inhabitants.

See the Logical Framework at Annex E for a detailed presentation of end-of-project status and purpose-achievement indicators, and of envisioned benchmarks.

III. FINANCIAL PLAN

A. A.I.D.

For this project, A.I.D. will provide $4,500,000 in FAA Section 104 Population and Health Program grant funds for technical assistance, training, commodities, vehicles, construction, operating expenses, local personnel support, promotional activities, evaluations, and audits over a four year period. The A.I.D. grant constitutes about 67 percent of the total project cost. The funding will be obligated in amounts sufficient to meet expenditures envisioned in the summary table entitled, "Summary of Project Costs by Year and Source of Financing," or to meet any amendments to this schedule.

B. GOT

The GOT will provide in-kind contributions valued at $2,200,000 over a four-year period to cover personnel, maintenance and depreciation of facilities, and operating expenses. The host government contribution constitutes about 33 percent of the total life of project funding and about 49 percent of the AID life of project funding.

Three summary tables and two detailed illustrative budget tables are set forth below. The contingency item includes a three percent inflation rate based on year one figures, compounded annually thereafter. Long-term personal costs have been based on a family of four. These summaries and the Detailed Budget show that the proposed funding is adequate to accomplish the project purpose in a timely manmner and, accordingly, that the project is financially viable.

TABLE I

1. Summary of Project Costs by Year and Source of Financing
($000)

Source	Year 1	Year 2	Year 3	Year 4	LOP
A.I.D.	1105	1590	1380	425	4500
GOT	100	700	700	700	2200
TOTAL	1205	2290	2080	1125	6700

TABLE 2

2. Summary of Project Costs by Expense Category and Source of Financing
($000)

Expense Category	A.I.D.	GOT	LOP
Technical Assistance	2150		2150
Commodities	391		391
Vehicles	84		84
Training	495		495
Construction	100		100
Local Op Exp./Local Project Personnel	1040	50	1090
Evaluation	175		175
Audit	30		30
MOH Personnel		2000	2000
MOH Facilities		150	150
Contingency	35		35
TOTAL	4500	2200	6700

TABLE 3

3. Detailed Illustrative Budget
($000)

Category	Year 1	Year 2	Year 3	Year 4	Total
Tech. Asst					
L/T	530	530	540	----	1600
S/T	75	75	50	----	200
Expat PSC	90	90	90	----	270
Local PSC	20	20	20	----	60
KAP Surveys	----	10	10	----	20
SubTotal TA	715	725	710	----	2150
Commodities					
IEC Materials	15	20	30	10	75
Vehicles	50	34	----	----	84
Office	25	41	----	----	66
Motorcycles	10	90	100	----	200
Computers	50	----	----	----	50
SubTotal Comms.	150	185	130	10	475
Training					
Plan/Budget	----	20	5	5	30
Teams	----	20	15	10	45
Agents/Outreach	10	20	20	10	60
Per Diem/Lcl. Tspt./Field Days	5	35	25	15	80
Mgt. seminars:in-country	----	60	60	----	120
US (2MA,$80K ea.)	80	80	----	----	160
SubTotal Training	95	235	125	40	495
Construction //	----	----	100	----	100
Local Op. Exp.					
Unit HQ	15	60	60	60	195
Vehicles POL	5	25	30	30	90
Motorcycles POL	60	140	135	120	455
Subtotal Local Op. Exp.	80	225	225	210	740
Local Personnel					
TA Adm/Fin Asst.	10	20	20	10	60
Unit Persnl Sal.	50	60	60	70	240
Subtotal Loc. Psnl.	60	80	80	80	300
Evaluation	----	100	----	75	175
Audit	----	30	----	----	30
Contingency	5	10	10	10	35
TOTAL	1105	1590	1380	425	4500

// About $10,000 of this item is planned to finance Architectural and Engineering Services.

TABLE 4

4. Summary Budget by Implementation Agent
($000)

Agent/Category	Year 1	Year 2	Year 3	Year 4	Total
LTTA	530	530	540	----	1600
STTA	75	75	50	----	200
KAP Survey	----	10	10	----	20
Local Op. Exp.	----	305	305	290	900
Commodities	85	151	130	10	376
Local Trng.	----	95	65	40	200
SubTotal	690	1166	1100	340	3296
AID Direct					
PSCs	110	110	110	----	330
USTraining	80	80	----	----	160
Mgt. Seminars	----	60	60	----	120
Local Op. Exp.	140	----	----	----	140
Vehicles	50	34	----	----	84
Commodities	15	----	----	----	15
Construction	----	----	100	----	100
Evaluation	----	100	----	75	175
Audit	----	30	----	----	30
Contingency	5	10	10	10	35
Lcl.Trng.Op.Exp.	15	----	----	----	15
SubTotal	415	424	280	85	1204
TOTAL	1105	1590	1380	425	4500

TABLE 5
Illustrative Budget by
Foreign Exchange (FX) and Local Currency (LC)
($000)

Expense Category	Year 1		Year 2		Year 3		Year 4		Total	
	FX	LC	FX	LC	FX	LC	FX	LC	FX	LC
L/T	530	---	530	---	540	---	---	---	1600	---
S/T	75	---	75	---	50	---	---	---	200	---
Expat. PSC	90	---	90	---	90	---	---	---	270	---
Local PSC	---	20	---	20	---	20	---	---	---	60
KAP Surveys	---	---	10	---	10	---	---	---	20	---
SubTotal TA	695	20	705	20	690	20	---	---	2090	60
Commodities										
Vehicles	50	---	34	---	---	---	---	---	84	---
Computers	50	---	---	---	---	---	---	---	50	---
Other	---	50	---	151	---	130	---	10	---	341
SubTotal Comms.	100	50	34	151	---	130	---	10	134	341
Training										
US MAs	80	---	80	---	---	---	---	---	160	---
Mgmt. Seminars (in-Togo)	---	---	60	---	60	---	---	---	120	---
Local	---	15	---	95	---	65	---	40	---	215
SubTotal Trng.	80	15	140	95	60	65	---	40	280	215
Construction //	---	---	---	---	50	50	---	---	50	50
Local OE&Psnl	---	140	---	305	---	305	---	290	---	1040
Evaluation	---	---	100	---	---	---	75	---	175	---
Audit	---	---	30	---	---	---	---	---	30	---
Contingency	5	---	10	---	10	---	10	---	35	---
TOTAL	880	225	1019	571	810	570	85	340	2794	1706

// About $10,000 of this item is planned to finance Architectural and Engineering services.

C. TITLE TO PROPERTY

Title to vehicles and commodities purchased with A.I.D. funds under this Grant shall vest in the project during implementation. Direct and indirect costs associated with their operation will be covered by this project. Upon project termination, final disposition of vehicles and commodities will vest in the MOH.

D. FINANCIAL MANAGEMENT OF LOCAL COSTS

Local costs under this project are substantial, largely because of extensive in-country training, mobilization of communities for Child Survival interventions, and support of technical advisors. It is envisioned that before the arrival of contractor technical assistance personnel, amounts needed to pay local costs will be advanced periodically to the GOT in accordance with the requirements of the A.I.D. Payment Verification Policy. The relevant policy is Policy Number Five which requires an assessment of a local organization's financial management procedures and related controls in the event that the organization will receive local currency and be responsible for controlling and reporting on its use.

For this project, the local organization will be the Child Survival Planning and Coordination Unit which will be created by the project. It will inherit the national accountant, the assistant national accountant, and the two regional accountants who currently are funded by the RWSS Project and serving under contract to the GOT. The GOT Implementing Agency for both projects is the MOH. In 1984, after promulgation of the Payment Verification Policy, the financial consulting firm of Akintola Williams performed extensive systems work and training of the above mentioned personnel to bring the project accounting system and personnel into compliance with Policy Number Five. The system has been working satisfactorily since then. The reader should be informed that contractor technical assistance personnel will be responsible for local currency management after their arrival in-country.

Two safeguards to assure continued compliance with Policy Number 5 are being undertaken this project:

1. A Condition Precedent to initial disbursement that the GOT furnish a statement indicating plans that: (a) the GOT shall enter into or extend the contracts, as part of the project, of the National Accountant, the Assistant Accountant, and the two Regional Accountants currently working under the Rural Water Supply and Sanitation project, and assign this staff to the Child Survival Planning and Coordination Unit; and, (b) the GOT shall utilize, except as agreed in advance in writing by A.I.D., for the Child Survival Planning and Coordination Unit, the accounting system and procedures in place under the Rural Water Supply and Sanitation Project for the management of A.I.D. advances.

2. The financing of a local hire accountant, under the technical assistance contract, to design (with short-term contractor technical assistance as required) and manage a financial accounting system to

properly control local currency advances made directly by the contractor to the Unit during the period the contractor is responsible for local currency management and accounting.

E. AUDIT REQUIREMENTS

One audit has been scheduled and budgeted for in month 25 at a cost of $30,000. This audit will be independent of the long-term technical assistance contract and will judge, inter alia, the systems put into place by the contractor to control A.I.D. funds.

F. ESTIMATED ANNUAL RECURRENT COSTS

The annual recurrent costs of maintaining project activities after project termination are $290,000, allocated as follows:

New motorcycles to replace worn out motorcycles	$ 60,000
Vehicle petrol, oil, lubricants, and repairs	30,000
Motorcycle petrol, oil, lubricants, and repairs	140,000
Personnel	30,000
IEC Materials	10,000
Per diem/transportation for outreach & adult education	20,000
	$290,000

IV. IMPLEMENTATION PLAN

Project activities are programmed to occur over a four year period from the signing of the Project Grant Agreement. The estimated Project Assistance Completion Date is September 30, 1991. A description of activities is set forth in the Detailed Project Description. The scenario for their implementation is presented in the Implementation Schedule set forth at Annex J. Some of the salient features of this schedule warrant discussion.

A. IMPLEMENTATION SCHEDULE FEATURES

The expatriate Agents' Assistant and the Togolese Teams' Assistant are scheduled to begin service in month four. Their presence will facilitate startup of activities under the Health Centers Support and the Outreach Network Components before those under the Planning and Coordination Component.

The schedule indicates that the first planning and budgeting exercise will be more laborious and take longer than subsequent undertakings. This difference is the natural result of the initial exercise requiring considerable in-service guidance which will be time consuming, partly because of the travel involved.

Project designers have realized that the envisioned project planning and budgeting scenario may not be compatible with the GOT fiscal year planning schedule. The schedule set forth in this Project Paper is illustrative only; implementation of the planning and budgeting exercise will be adjusted to coincide with the GOT's standard procedure. However, every attempt will be made to adhere to the training schedule for this exercise because the Senior Advisor/Health Planner and the IEC Specialist have other responsibilities scheduled for later project months. Precautions are being taken against trainees' forgetting how to undertake planning and budgeting in the event that the interval between training and implementation of the exercise is significant. Trainees will be furnished with detailed written instructions on how to prepare their respective submissions, and they will be able to obtain in-service assistance at their workplace for the asking.

Scheduling of activities for the Health Centers Support and Outreach Network Components in greater detail than has been provided would be premature. The activities are too numerous and diverse, both in terms of disciplines and in terms of geography, to be amenable to detailed scheduling at this time. The Detailed Project Description and the Logical Framework are sufficiently explicit regarding the kinds of activities and interventions envisioned, and the nature of the beneficial results anticipated, to give the technical assistance team and the Unit sufficient direction. These personnel must be able to take advantage of targets of opportunity in cooperating with other agencies, and must be resourceful in creating mutually beneficial opportunities through Collaborative Protocols. This is an implementation-phase challenge which cannot be scheduled productively at this juncture.

B. ADMINISTRATIVE PLAN

1. GOT Responsibilities

a. Grantee Implementing Agency and Implementing Unit

The GOT Implementing Agency is the Ministry of Public Health, Social Affairs, and Women's Condition (MOH), and the project-sponsored Child Survival Planning and Coordination Unit (the Unit) is the operational implementing entity. Key supervisory GOT personnel are the Minister of Health and the Directors General of Public Health, Social Affairs, and Women's Condition.

b. Participation of Grantee Personnel

The GOT has agreed to make available a senior GOT official with extensive experience in planning, budgeting, and public administration to serve full-time as Unit Director. This official may be seconded from the Ministry of Plan. The GOT also has agreed to make available two senior MOH officials to serve as full-time Unit Coordinators. Ideally one Unit Coordinator will be drawn from the Directorate of Public Health and the other from the Directorate of Social Affairs. The MOH has further agreed to make available members of Prefecture Health Education Teams, up to 120 Community Agents in Plateaux and Savanne, and Public Health personnel nation-wide serving in Health Centers for in-depth participation in project activities, and the premises of Health Centers.

c. Planning and Coordination Unit Responsibilities

This Unit is responsible for publishing a ten-year National Child Survival Policy and Strategy Paper and an eight-year Child Survival Training Plan and Illustrative Budget, compiling an inventory of ongoing and proposed Child Survival-related activities in Togo, and arranging for the preparation of a Recurrent Costs Study and for KAP Surveys. With the advice of its Advisory Board it will designate the members of the operational level National Commission for Child Survival. Its most challenging sustained responsibility is the design and execution of an annually-undertaken Child Survival planning and budgeting exercise covering five years each time. Duties related to this exercise include: preparation of training materials, manuals, standardized forms, instructions on form completion, and cost indices; field testing of materials and forms; training of national, regional, and prefecture level MOH officials in the skills required for their respective participation; follow-up assistance; data analyses; Plan and Budget Recommendation drafting and advocacy; and review assessment for those involved in submitting input to the process.

Unit personnel also are assigned the task of coordinating with medical teaching institutions to assure integration of Child Survival subjects into their respective curricula. The Unit is responsible for co-drafting (with the other signatory party) project Collaborative Protocols with MOH entities and other organizations able and willing to provide technical and communications skills training.

These Accords will specify in detail schedules, locations, commodity procurement, activities to be undertaken, division of responsibility among participating groups, and budgets. The Unit is further charged with the daily follow-through of all inter-agency Child Survival coordination initiated by the Commission, and serves as Commission Secretariat.

The Unit Coordinator from Public Health will focus almost exclusively on learning, applying, and teaching the planning and budgeting process. The Unit Coordinator from Social Affairs will spend about half of his or her time learning, applying, and teaching the planning and budgeting exercise, and the other half supervising the Outreach Network Component Activities. This Coordinator will have final approval authority for initiation of that component's activities and for disbursements for those activities.

The Unit will inherit the accounting staff from the RWSS Project. This staff will manage local currency advances using the same procedure it has used under the RWSS Project until arrival of technical assistance contractor personnel, at which time management of local currency advances will be transferred to them.

d. Advisory Board Responsibilities

The Advisory Board, composed of the three MOH Directors General, will guide definition of and approve the content of the Policy and Strategy Paper and of the Plan and Budget Recommendations accruing from the annual planning and budgeting exercise. Its members can be expected to use their good offices at high levels of the GOT to promote resource allocations to Child Survival. The Board will meet at least twice a quarter.

e. National Child Survival Commission Responsibilities

The Commission will meet at least twice a quarter and function at the operational level to assure that all agencies interested and active in Child Survival are informed of each other's efforts, to facilitate coordination, and to avoid duplication and fragmentation of effort. Its members will use their international contacts to solicit funds for Child Survival activities in Togo. The Unit will work through the Commission to arrange for project-financed technical and pedagogical training under Collaborative Protocols for Teams and Agents.

f. National Health Education Service (SNES) Responsibilities

The GOT National Health Education Service located within the Public Health Division of Public Hygiene and Health Promotion is the mobilizer, organizer, and chief training entity for the Prefecture Health Education Teams. At the central level it will coordinate closely with the Teams' Assistant in arranging project-sponsored and -facilitated training and other project-sponsored activities for these Teams. Its regional offices will facilitate and monitor the Teams' instruction of Public Health personnel envisioned by this project. With project

financing and technical assistance, SNES will undertrake project-related IEC activities, including mass media publicity, preparation of promotional materials, and design and drafting of reference materials for MOH field workers and their clients.

2. A.I.D. Responsibilities

a. USAID/Togo

The Office of the A.I.D. Representative in Togo currently is allocated one USDH, a General Development Officer (GDO), for the period of the project's implementation. The GDO will devote about 50 percent of his/her time to the project and will be the primary Mission Officer responsible for implementation. This Officer's implementation responsibilities will start before the Project Agreement is signed with preparation and processing of PIO/Ts and PIO/Cs, and with local advertising for services. As soon as the Project Agreement is signed, the GDO will order equipment, commodities, and vehicles needed by technical assistance personnel upon their arrival. During implementation, the GDO will be responsible for project planning, budgeting, monitoring, reporting, arranging U.S. training and in-country management seminars, and obtaining necessary clearances and timely decisions from the Mission, REDSO/WCA, and AID/W. The GDO will also serve as liaison among the Mission, participating GOT entities, the technical assistance contract team, Teams' and Agents' Assistants, and the various agencies participating in this project's implementation through Collaborative Protocols.

b. REDSO/WCA

The West Africa Accounting Center (WAAC) serves as the USAID/Togo controller. Other regional offices critical to this project's impelementatin are those for legal services, contracting, commodity procurement, population and health, and engineering.

c. AID/W

Backstopping by AFR/PD/CCWAP, and appropriate assistance of health and population personnel, from both the Africa Bureau and the Bureau of Science and Technology, will be provided.

3. Technical Assistance Contractor Responsibilities

The Senior Advisor/Health Planner and IEC Specialist will be stationed at the Unit. The Advisor/Planner will be the counterpart to the Unit Director and serve as head consultant for the planning and budgeting exercise, and for drafting of the Policy and Strategy Paper, Training Plan, Child Survival Inventory, and Recurrent Costs study. The IEC Specialist will work closely with SNES, the Teams' and Agents' Assistants, and with the Unit Coordinator from Social Affairs, and will give or supervise a significant amount of the Teams' and Agents' training. The contractor will be responsible for its personnel's housing, commodity procurement (except vehicles) and, after its long-term personnel's arrival in-country, for management of and accounting for

local currency advances. The contractor will engage a local-hire administrative/financial assistant to facilitate its execution of these duties.

4. Teams' Assistant and Agents' Assistant Responsibilities

The Teams' Assistant will organize, monitor, coordinate and otherwise facilitate project-financed and -facilitated activities related to the Teams' mobility and training and Teams' instruction of Public Health personnel. The Agents' Assistant will organize, monitor and otherwise facilitate project-financed and facilitated activities related to the Agents' mobility and training, and to Agents' Child Survival village outreach activities and conduct of Child Survival Field Days. Both Assistants will facilitate conduct of project KAP surveys. Although both will be stationed at the Unit, they will spend over 50 percent of their time in the field, and their combined presence will be the major continuing project field representation.

The above-identified A.I.D. direct-hire and A.I.D.-funded resources are deemed sufficient to accomplish project implementation in an effective and timely manner.

5. Collaborating Agency Responsibilities

The most significant organizations with which Collaborative Protocols are envisaged are: CCCD, for IEC and technical training; UNICEF, for health education and technical training; Cathwell for training in nutrition; ATBEF for training in voluntary birth spacing; and PVOs and religious organizations (such as World Neighbors and the Baptist Mission) for community outreach.

6. Local Logistics and Administrative Arrangements

Detailed local logistics and administrative arrangements will be specified in the Project Agreement and in Project Implementation Letters. The following basic provisions will be included:

-- all facilities, furnishings, vehicles, motorcycles, and useable commodities financed by A.I.D. under the Rural Water Supply and Sanitation Project will be made available to the Unit to support this project's activities;

-- all vehicles and motorcycles will be under the general control and supervision of the Unit Director;

-- all vehicles' and motorcycles' fuel will be tax free and will be purchased directly by the Unit from the U.S. Embassy and other sources;

-- commodities financed by and imported for the project will be allowed to enter the country tax free; and,

-- the MOH will staff and continue operations of two regional motorcycle repair garages established by the RWSS Project for the life of this project.

C. PROCUREMENT PLAN

1. Technical Assistance

Long-term assistance will be procured both through a contract with a U.S. firm and through Personal Services Contracts (PSCs). Thirty-six months of service of each a Health Planner and of an Information-Education-Communications Specialist will beprocured competitively through 8(a) procedures in AID/W. This assistance will be solicited from firms specializing in fielding and backstopping health experts and having a great deal of experience in managing A.I.D. funds overseas. The contract will include provisions for engaging a local-hire financial and administrative assistant to manage A.I.D. funds and project commodity procurement. In addition, seventy-two months of services under two Personal Services Contracts will be procured by USAID/Togo for support of overall project monitoring, particularly in the field. The detailed scheduling of these procurements, and coordination with AID/W for the technical assistance contract, have been set forth in the Implementation Schedule. The project will finance a total of 108 person months, or 9 person years, of long-term, expatriate technical assistance and 36 person months, or 3 person years, of Togolese technical assistance, as follows:

Specialist	Person Months	Project Service Months
Senior Advisor/Health Planner	36	9-44
IEC Specialist	36	9-44
Togolese PSC Teams' Assistant	36	4-39
Expatriate PSC Agents' Assistant	36	4-39
TOTAL	144	

Budgeted funds are sufficient to finance 16 person months of short-term technical advisory services under the contract. Requirements for these services will be identified after the long-term personnel and the Unit Director have had sufficient opportunity to determine gaps in the MOH's expertise and to ascertain the optimal mix of specialities required. The Contractor will finance up to two KAP surveys on an appropriate project issue. These surveys will be conducted by Togolese or locally-available U.S. students as part of a graduate study program. Accordingly the cost of these surveys will be modest, with only actual expenses and a minimum wage paid.

2. Construction Services

The Minister of Health has requested construction of up to two very modest Child Survival Demonstration Centers under the project. Development of the request to A.I.D. will be the responsibility of the Unit and, if approved, engineering and construction will be undertaken under a direct AID contract arrangement. USAID/Togo, with REDSO/WCA/ENG assistance, will approve construction plans, and a REDSO/WCA engineer will make periodic site visits until construction has been completed. Any proposed contracts relating to construction will be reviewed and concurred in by the regional legal and contracting officers.

3. Commodities

At this juncture it is premature to draft a detailed commodity list. However, certain commodity needs can be foreseen, such as those for vehicles, motorcycles, petrol, oil, and lubricants for motorcycles, two micro-computers, expendable and non-expendable office equipment, office furnishings, and IEC and teaching materials. Computer purchases will be under $100,000, and, accordingly, SER/IRM approval is not required.

a. Responsible Agency

Before the contractor-fielded techical assistance team arrives in country, USAID/Togo will be responsible for commodity procurement. Thereafter the contractor will be responsible for commodity procurement in accordance with A.I.D. regulations.

b. Source and Origin, and Shelf Item Procurement

The authorized source and origin of project commodities is A.I.D. Geographic Code 941 plus the host country. In addition, free world shelf items (those originating in countries included in Code 899 but not code 941) may be procured locally within the limits set forth in A.I.D. Handbook 1, Supplemental B, Chapter 18, subsequent to USAID/Togo's certification that prices are reasonable. Prices paid for locally procured commodities will be no more than the lowest available competitive prices, and purchases will be in accordance with good commercial practice. Invoices for locally purchased commodities should state their source and origin to the extent practicable. The required A.I.D. Representative's Determination is included at Annex B.

c. Motor Vehicles

An approved source/origin waiver from A.I.D. Geographic Code 000 to Code 935, and of the requirement of Section 636(i) of the Foreign Assistance Act of 1961, as amended, is included at Annex F. The waiver permits purchase of two heavy duty sedans, one light duty sedan, one station wagon, and one four wheel drive utility vehicle and spare parts for each. The estimated cost of the waived procurement is $84,000. Vehicles of U.S. manufacture, and spare parts and service facilities for them, are not available in Togo. The Mission has not established a vehicle standardization plan, and has no plans for doing so. Procurement of non-U.S. manufactured motorcycles is authorized under a blanket source and origin waiver for one wheel drive motorcycles of 125cc displacement or less.

d. Delivery, Receipt and Utilization

All project commodities imported into Togo will be shipped CIF Lome. Suppliers will provide all-risk marine insurance in the amount of 120 percent of the CIF cost of the commodities, and similar insurance on inland freight. A.I.D. marking requirements for overseas shipment will be observed by suppliers of commodities.

The GOT is responsible for proper receipt and clearance of incoming project commodities. Inspections of incoming shipments must be made, and receiving documents must be annotated with comments on evident damages and/or losses. The GOT will file claims when necessary.

Project goods will be transported immediately to the site of their intended use upon customs clearance and put to project use as soon as possible thereafter. The Mission will regularly inspect use of project commodities, and the GOT's and technical assistance personnel's compliance with A.I.D. marking requirements for all project-financed commodities.

D. TRAINING PLAN

Two of this project's important early implementation activities are related: compilation of an Inventory of all ongoing and proposed Child Survival activities in Togo; and, preparation of an eight year Child Survival Training Plan and Budget. The Senior Advisor/Health Planner and IEC Specialist will have backgrounds and experience in health training to complement their respective primary expertise. It is probable that some of the budgeted short-term technical assistance will be allocated to assisting these two long-term personnel with the Inventory and Training Plan. The Training Plan's eight-year projections will emphasize using locally available sources of pedagogical instruction and technical expertise, such as CCCD, UNICEF, ATBEF, Cathwell, and others. This project's emphasis is on in-country, in-service training. This on-the-job guidance will be both intensive and extensive, being provided at frequent intervals for project personnel at all levels from GOT officials in the Unit, to regional and prefect-level MOH supervisory staff, to Team members and Community Agents, and to villagers during Field Days. An explanation of the projected scenario for the planning and budgeting training is set forth in the Technical Analysis and Implementation Schedule. A discussion of the envisaged operation of Teams' and Agents' training is provided in the Detailed Project Description.

Because the MOH has no officials on its staff with degree training in planning or administration, funds for up to two U.S. Masters degrees in health planning or administration and for up to two in-country management seminars (of the type given by the University of Pittsburgh) have been budgeted. USAID/Togo is administratively responsible for arranging the U.S. Masters training and the management seminars, and the GOT, with USAID/Togo concurrence, is responsible for identifying the participants.

V. MONITORING AND EVALUATION PLAN

A. PROCEDURES AND REPORTING REQUIREMENTS

The Unit Director, the Senior Advisor/Health Planner, and the GDO will establish project review, appraisal, and reporting procedures for implementation by the technical assistance contractor and the Teams' and Agents' Assistants, the project implementation entities -- i.e., the Unit, the Board, and the Commission, participating GOT entities, agencies cooperating under Collaborative Protocols, and the Mission. These procedures will consist of, at a minimum:

-- Monthly surveys by the Unit Director, Planner/Advisor, and the GDO in order to identify impediments early and thereby minimize their impact;

-- Quarterly reports by all key project personnel using a brief format developed for each personnel category to assure that all essential matters are reported on, that reported information by each personnel category meshes with and is meaningful to that reported by other categories, and that unsolicited information, suggestions, and problem anticipation and identification are invited. Those responsible for submitting quarterly reports will include, but not be limited to, Community Agents, Team members, Agents' and Teams' Assistants, Regional Accountants, the Unit Director and Coordinators, the Chief National Accountant, the Advisor/Planner, the IEC Specialist, the contractor's financial/administrative assistant, the Board President, the Commission Chairman, and the GDO;

-- Quarterly Project Reviews held shortly after submission of the above-described Quarterly Reports and based on them. Minutes will be kept of these Reviews, which will be conducted by a group composed of the Unit Director, the GDO, the Advisor/Planner, and Teams' and Agents' Assistants;

-- Establishment of a Project Task Force consisting of the Unit Director, the two MOH Unit Coordinators, the A.I.D. Representative, the GDO, the Advisor/Planner, the IEC Specialist, the Teams' and Agents' Advisors, the Chairman of the Board, and the President of the Commission;

-- Project Task Force meetings at least one every six months immediately before preparation of the Six-Month Project Report discussed below to address matters covered in the report;

-- Project Task Force meetings on an ad hoc basis to identify and analyze serious implementation problems, and to draw high level attention of the donor community and of the host government to their resolution; and,

-- Six-month Project Reports to the A.I.D. Representative prepared by the Unit Director with the assistance of the Advisor/Planner on the basis of the preceding Task Force Meeting, with contributions from all Unit members and long-term technical assistance personnel. These reports, at a minimum, will describe implementation progress under each component, problems and delays encountered, and responsive corrective actions taken and/or requested, and address certain key concerns outlined below. The

reporting format for this document will be developed by the Unit Director, the Advisor/Health Planner, and the GDO, and refined thereafter to meet A.I.D. reporting and Mission monitoring needs.

B. KEY CONCERNS TO BE MONITORED

Special attention will be paid to the following concerns:

1. Recurrent Costs

The Unit, the Project Task Force, and the Mission will be responsible for monitoring recurrent expenditures on an annual basis. At the end of each GOT fiscal year, a statement of recurrent expenditures incurred will be developed by the Unit Director, assisted by the Advisor/Planner, for review by the Project Task Force. The statement will be organized by project component and disaggregated to the maximum extent possible. A continual effort will be made to keep recurrent costs at minimum levels and to establish a composition of activities and a rate of expenditure sustainable by the GOT at the end of the project. A continuing inquiry will be made, and experiments conducted, to assess the extent to which user fees for health services are an option for at least partially financing service delivery.

2. Effectiveness of Vertical and Horizontal Communication

Effective communication is at the core of both of this project's components. It is imperative for the success of the planning and budget exercise, and must flow freely in two directions, from the center to the prefectures, and back. Regarding the Health Centers and Outreach Network Components, communication, cooperation, collaboration, and involvement are watchwords of effective service delivery and network formation. Special scrutiny will be given to the progress made in the improvement of bottom-up and horizontal communication within and among organizations (including governments, donors, and PVOs) at all personnel levels. Also special attention will be given to the extent to which rural women are actively involved in project undertakings and availing themselves of project resources and benefits. Suggestions for ways in which the project can improve communications will be sought and tested.

3. Women's Concerns

The Division of Social Education within the Directorate of Women's Condition and the Division of Maternal and Child Health within the Directorate of Public Health were created to safeguard women's needs and to assure their access to the resources available through, and benefits of, development activities. This project is fortunate to have them as project participants. The monitoring process must ensure that every effort is made to recruit women as Team Members and Community Agents, that women are project participants and beneficiaries at all levels, that data collection and management systems, planning procedures, and network structures are designed to take gender differences into account, and that field level activities accomodate rural women's priority Child Survival concerns.

C. EVALUATION

There will be two external evaluations: the mid-term during the 21st month and the final during the 38th month, just before the departure of the Teams' and Agents' Assistants. Each evaluation will require three to four persons from various disciplines. They will be organized by the Mission in collaboration with REDSO/WCA and/or AID/W, and with Unit personnel. The mid-term evaluation has been budgeted for $100,000 and the final for $75,000. These funds will be retained outside the technical assistance contract. Contracting for evaluation services will be by the Mission, assisted by REDSO/WCA.

The mid-term evaluation will assess:

--Grantee commitment with respect to satisfaction of the condition precedent to further disbursement;

-- the degree to which inputs have been provided efficiently;

-- the degree to which outputs have been and are likely to be realized on schedule;

-- the degree to which sufficient quality and quantity of information is being collected, managed, and analyzed to enable assessment of project progress;

--overall project management by the Grantee, A.I.D., and the contractors;

-- A.I.D. strategy in supporting the Planning and Coordination Unit, especially in relation to other donor's activities;

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

-- the advisability of increasing the life-of-project funding from the authorized level to the planned level, and detailed justification for the recommendations made;

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

-- the degree to which women are able to avail themselves of project benefits and participate in project activities;

-- the degree to which information and ideas are being communicated as a result of the project, and to what extent formal and informal linkages among involved entities and individuals have been developed; and,

-- the degree to which recurrent costs are being and can be further minimized.

The final evaluation will focus on the realization of end-of-project status indicators. It will analyze the sustainability and value of the annual planning and budgeting exercise. It will report on the benefits and cost effectiveness of the Teams' and Agents' activities. It will assess the impact of community outreach operations on the quality of health service delivery and on the rural population's ease of access to Child Survival services. It will attempt to project the extent to which improvements in infant and child mortality and morbidity statistics can be expected -- by when -- or, alternatively, specify the process by which the extent of improvement will be projected, and, ultimately, measured.

and indicate when this process can be initiated. It will analyze the effectiveness and replicability of this project's Outreach Network activities with special scrutiny and ascertain donor interest in sponsoring dissemination of such activities. The final evaluation will analyze the need, if any, for continuing A.I.D. or other donor support to Child Survival in Togo, and the form such support should take. Finally, it will assess the advisability of any continued A.I.D. role in Togo's health sector, taking into consideration other donors' ongoing and planned interventions and any seminal changes wrought by the significant World Bank-sponsored health sector reform and support program, from which returns should be coming in by the time of this evaluation.

VII. SUMMARY OF PROJECT ANALYSES

A. INSTITUTIONAL SOUNDNESS AND ADMINISTRATIVE FEASIBILITY

Several factors contribute to this project's institutional soundness and administrative feasibility. First, for maximum effectiveness, the major host country implementing entity, the Planning and Coordination Unit, is placed directly under the Minister of Health, secondly, this Unit will be staffed by an optimal combination of GOT personnel with this project implementation capacity under the guidance of a highly trained and specially selected Togolese health planner who will serve as the Unit Director. U.S. technical advisors will assist this project management in the areas of health planning and IEC. A number of training and in-service guidance programs will also be funded under the project to assure that an effective MOH planning, budgeting and coordination capacity exists and will continue to function effectively at the completion of the project.

Health Center Support and Outreach Network Components employ initiatives and administrative systems which the MOH is using and seeking to strengthen. These components' conceptual framework was carefully selected from among alternative approaches of improving and expanding Child Survival services as those likely to have maximum beneficial impact.

B. TECHNICAL

The training content and methodologies, and the techniques and technologies envisioned for project use are approprite to the Togolese context and will be predictably effective in contributing to achievement of the project purpose. Planning, budgeting, and managerial coordination skills already have been successfully taught in Togo with sustained successful results. Interventions focus on developing an appreciation of, and on increasing the use of technologies of proven effectiveness in rural areas in developing countries and on instructing villagers in home-administered Child Survival measures of proven effectiveness.

C. ECONOMIC

An improved capability to plan, budget and coordinate Child Survival activities will result in a better allocation of scarce resources. Trained staff will be able to identify needs, determine costs of resources needed, and present reasonable budgets which are more likely to obtain budget allocations. A demonstrated capability to effectively manage resources will lead to lessening of reliance by donors on expatriate technical assistance to ensure effective project implementation thereby allowing more funds to be available for service delivery. The MOH's declining share, in real terms, of the national budget is believed to be due to a lack in confidence in its ability to manage well these resources. A demonstrated capacity to better manage national resources should therefore result in increased budget allocations for health activities.

Rural health facilities and their staff are underutilized because the rural population is poorly informed about what health care treatment is available and is discouraged by the unresponsive health delivery system. The provision of health care services provided in a professional manner to an informed population will increase the numbers who avail themselves of such services, resulting in a more effective use of facilities and staff. Where such services are not readily available, a more informed population will be able to practice a limited number of home-prepared techniques and be better informed as to where to seek more sophisticated services. These improvements in management efficiency and health standards imply very large economic benefits.

The Health Centers Support and Outreach Network Components rely on existing health promotion systems with relatively small amounts of project funding used to enhance these activities. On the other hand, achieving the mobility necessary to reach a large, dispersed rural population requires an investment in motorcycles and associated costs. The planning and budgeting under this project should facilitate MOH financing of these costs. The recurrent costs engendered by this project are therefore minimized.

D. FINANCIAL

The financial implications of the Planning and Coordination Unit and the Community Outreach components are quite different. The former is largely financed from the project as no such central function exists in the MOH. In the case of the latter, financing of project activities is predominately from MOH resources and other donors. In both components, however, disbursement mechanisms for AID funds have been chosen to reduce USAID's direct administrative workload on its small staff while retaining adequate financial controls. Such mechanisms include direct Contractor disbursement of local costs and maximum use of the Unit for obtaining locally available goods, services and facilities for in-country training. Prior to the arrival of the technical assistance contractor, USAID will account for local cost disbursements, using a financial system transfered from a terminating project which has demonstrated a satisfactory capacity to account for AID funds.

E. SOCIAL SOUNDNESS

The project's social soundness is based on its broad beneficiary base, on the potential for spread effect of its activities, and in its high socio-cultural feasibility. Obtaining maximum spread effect has been built into project activities. Planning and management skills can be expected to be applied throughout the primary health care system after having proven their usefulness as applied to Child Survival. The rural outreach systems are expected to be widened and replicated. Beneficiary participation has been and will be one of the key elements of this project's feasibility. By nature, Child Survival activities involve participation of women and necessitate access of women to project benefits. Also this project will help equalize the accessibility and quality of health care throughout Togo. The national scope of project activities will therefore help lessen regional inequities in the delivery of health services. Project benefits will be available to all groups and have been designed to assist the Togolese to help themselves.

F. ENVIRONMENTAL SOUNDNESS

The institution building, training, Child Survival interventions and constructon activities meet criteria for a Categorical Exclusion because they will neither directly affect the environment nor have significant adverse impact on the environment.

VII. CONDITIONS, COVENANTS, AND NEGOTIATING STATUS

A. CONDITIONS PRECEDENT TO INITIAL DISBURSEMENT

Except as A.I.D. may otherwise agree in writing, prior to any disbursement under this project, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the Grantee shall furnish or have furnished to A.I.D., in form and substance satisfactory to A.I.D. within ninety (90 days) after the signing of the Project Agreement:

1. A statement setting forth the name and title of person holding or acting in the Office of the Grantee specified in Section 8.2 of the Project Agreement, and of any additional representatives, together with a specimen signature of each such person, certified as to its authority.

2. Documentary evidence that the Child Survival Planning and Coordination Unit has been established and will exist at least through the life of the project.

3. Evidence, through the issuance of appropriate documentation, that the Grantee has assigned for full time, life of project service to the Child Survival Planning and Coordination Unit, a National Child Survival Unit Director, with extensive training and experience in planning and management, who is acceptable to A.I.D.

4. A statement indicating plans that: (a) the Grantee shall enter into or extend the contracts, as part of the project, of the National Accountant, the Assistant Accountant, and the two Regional Accountants currently working under the Rural Water Supply and Sanitation Project, and assign this staff to the Child Survival Planning and Coordination Unit; and, (b) the Grantee shall utilize, except as agreed in advance in writing by A.I.D., for the Child Survival Planning and Coordination Unit, the accounting system and procedures in place under the Rural Water Supply and Sanitation Project for the management of A.I.D. advances.

B. CONDITION PRECEDENT BEYOND THE TWENTY-FOURTH PROJECT MONTH

Except as A.I.D. may otherwise agree in writing, prior to any disbursement or the issuance of any commitment documents under this Agreement beyond the twenty-fourth project month, an in-depth evaluation conducted during the twenty-first project month specifically must have concluded that there had been evidence of sufficient GOT commitment to the project during the first twenty-one months to warrant a recommendation for project continuation. At a minimum this evidence must consist of: satisfactory application of effective procedures developed for implementing the project; satisfactory performance of the Unit Director; satisfactory performance of each senior MOH official seconded to the Unit for service as Unit Coordinator; full operation and satisfactory effectiveness of the Unit and the Advisory Board; satisfactory quality, quantity, and promptness of cooperation forthcoming

from MOH entities (including, but not limited to, the National Health Education Service, the Division of Epidemiology, the Division of Maternal and Child Health, and participating agencies of the Directorate of Social Affairs), which have expertise and resources needed for project implementation; satisfactory, appropriate facilities having been obtained by the Grantee for the Child Survival Planning and Coordination Unit; and, a detailed GOT Plan, in which A.I.D. has concurred, for the GOT's assuming the costs of petrol, oil, lubricants, and repairs for the motorcycles used by Teams and Community Agents so that these groups retain their full mobility after the project ends.

C. CONDITION PRECEDENT TO DISBURSEMENT FOR CONSTRUCTION

Except as A.I.D. may otherwise agree in writing, prior to any disbursement for construction of facilities the Grantee shall furnish to A.I.D. completed building plans, material estimates, cost estimates and other related documents necessary to determine the cost of construction and its specifications.

D. COVENANTS

The Grantee shall covenant:

1. That appropriate capital assets acquired under the Togo Rural Water Supply and Sanitation Project, including but not limited to office furnishings and equipment, motorcycles and other vehicles, and equipment and tools for the repair of motorcycles, shall be transferred to the Project at a time and in a manner satisfactory to the Ministry of Health and to A.I.D.

2. That the community based health delivery system of the Rural Water Supply and Sanitation Project, including but not limited to its Agents and their motorcycles, shall be available to support the Project, and that the Grantee shall pay the overhead and personnel costs associated with the motorcycle repair facilities located in the Plateaux and Savanne regions.

3. That one Senior Public Health Officer and one Senior Social Affairs Officer shall be assigned full-time to the Child Survival Planning and Coordination Unit as Unit Coordinators for the life of the project.

E. NEGOTIATING STATUS

The above Conditions Precedent and Covenants have been discussed with and agreed to by the Minister of Health and his Cabinet Director. During Project Agreement negotiations, the A.I.D. Representative, Togo, will incorporate into the Agreement appropriate language to cover these terms and conditions.

FLD APPROVAL

UNCLASSIFIED STATE 048270

0228

ACTION: AID INFO: AMB DCM CHRON

LOC: 041 369
19 FEB 87 0230
CN: 25472
CHRG: AID
DIST: AID

ACTION DOD
GPORT JSIMDPALPOQ
AYGJYNL K
SGVZCZCLMO670LHU611
OO RUFHPC
DE RUEHC #8270 0500228
ZNR UUUUU ZZH
O R 190226Z FEB 87
FM SECSTATE WASHDC
TO RUFHPC/AMEMBASSY LOME IMMEDIATE 8799
INFO RJLHAB/AMEMBASSY ABIDJAN 1570
BT
UNCLAS STATE 048270

AIDAC

E.O. 12356: N/A

SUBJECT: TOGO HEALTH SECTOR PLANNING GRID (693-0228)

ECPR MET ON FEBRUARY 13, 1987 AND APPROVED SUBJECT PROJECT FOR PP DESIGN AT THE REQUESTED LOP FUNDING OF US DOLLARS 3,750,000. GUIDANCE CABLE WILL FOLLOW LATER.
SHULTZ
BT
#8270

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UNCLASSIFIED STATE 048270

USAID/TOGO - LOME
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2/19 Annex A

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UNCLASSIFIED STAT 062500 0228

ACTION: AID INFO: AMB DCM CHRON

VZCZCLMS-C8EHV333
RR RUEHPC
DE RUEHC #2500 0630339
ZNR UUUUU ZZH
R 040537Z MAR 87
FM SECSTATE WASHDC
TO RUEHPC/AMEMBASSY LOME 2927
INFO RUEHAB/AMEMBASSY ABIDJAN 1981
BT
UNCLAS STATE 062500

LOC: 050 4?? 04 MAR 87 0404
CN: 06286
CHRG: AID
DIST: AID

AIDAC

E.O. 12356: N/A

SUBJECT: GUIDANCE FOR PP DESIGN OF TOGO HEALTH SECTOR PLANNING AND SUPPORT, (693-0228)

1. ECPR HELD ON FEBRUARY 13, 1987 WAS CHAIRED BY JAMES GRAHAM, ACTING DIRECTOR, AFR/PD AND WAS ATTENDED BY OAR/LOME, AFR/PD/CCWAP, GC/AFR, AFR/TR/HNP, AND AFR/DP/PAB. PP GUIDANCE RESULTING FROM ECPR FOLLOWS.

2. AS REQUESTED BY AID REPRESENTATIVE/LOME, COPIES OF PP AND ISSUES PAPER POUCHED TO LOME AND ABIDJAN. REVIEW RAISED ONE MAJOR ISSUE AND SEVERAL SUBSIDIARY CONSIDERATIONS.

3. MAJOR ISSUE. GIVEN THE MINISTRY OF HEALTH'S PAST RELUCTANCE TO DO FORMAL PLANNING, WHAT IS THE LIKELIHOOD OF INSTITUTIONALIZING AND STAFFING A CHILD SURVIVAL PLANNING AND COORDINATION UNIT WITHIN THE MOH?

ECPR CONCLUDED THAT APPOINTMENT OF CS COORDINATOR BE A CONDITION PRECEDENT FOR INITIAL DISBURSEMENT.

A SECOND CP WOULD REQUIRE DEMONSTRATION OF GOT'S COMMITMENT TO THE PROJECT AFTER A YEAR'S OPERATION. IT IS SUGGESTED THAT AN EVALUATION ASSESS GOT'S COMMITMENT AS WELL AS AID'S STRATEGY IN SUPPORTING NATIONAL PLANNING UNIT IN RELATION TO OTHER DONORS' INITIATIVES.

4. SUBSIDIARY CONSIDERATIONS.

A. NATIONAL VS. REGIONAL SUPPORT. ECPR CONFIRMED OAR/LOME'S POSITION OF SUPPORTING CHILD SURVIVAL PLANNING AT THE NATIONAL LEVEL IN ORDER TO COORDINATE DONOR AND REGIONAL EFFORTS, TO AVOID DUPLICATION AND TO CONSERVE RESOURCES.

B. PERFORMANCE TARGETS. ECPR RECOMMENDED THAT DESIGN TEAM SET MORE REALISTIC PERFORMANCE TARGETS RATHER THAN REITERATING THE GLOBAL TARGETS OF THE CCCD PROJECT. THIS TASK SHOULD INCLUDE DEVELOPING MEANS TO ASSESS PERFORMANCE OF CS UNIT'S MANAGEMENT

Annexe A

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I.E., ABILITY TO PLAN AND TO SOLVE PROBLEMS; MOH'S EXPECTED INPUT INTO PLANNING FOR KEY PROJECT AREAS; EXPLORE DATA FOR ESTABLISHING A PROJECT MONITORING SYSTEM,

C. NUTRITION COMPONENT. THE ECPR RATIFIED THE NEED TO SPECIFY HOW NUTRITION SURVEILLANCE WILL BE INCORPORATED INTO THE PROJECT.

D. CONTRACTING METHOD. ECPR CONCLUDED THAT THE PP TEAM SHOULD IDENTIFY AND EVALUATE A RANGE OF CONTRACTING MODES FOR PROVIDING PROJECT TECHNICAL ASSISTANCE. THESE WOULD INCLUDE REDUCING OR CONTINUING THE ROLE OF CENTER FOR DISEASE CONTROL (CDC), MEDICAL SERVICES DEVELOPMENT (MSD), AND FAMILY PLANNING INTERNATIONAL ASSOCIATION (FPIA); EXPANDING THE ROLE OF CDC, MSD, AND FPIA WITH COMPLEMENTARY INSTITUTIONAL OR PSC ASSISTANCE; CONTRACTING ALL TA NEEDS WITH A SEPARATE INSTITUTION SUCH AS A UNIVERSITY; OR, USING A COLLABORATIVE MODE.

5. AID/W UNDERSTANDS THAT MISSION IS REVIEWING HOST COUNTRY CONTRIBUTION FOR COMPLIANCE WITH SECTION 110(A). WHITEHEAD
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ANNEX B

LOCAL COST FINANCING DETERMINATION

In accordance with A.I.D. Handbook 1B, Chapter 18, the A.I.D. Representative/Lome hereby authorizes local cost financing for certain goods and services to be procured under the Health Sector Support for Child Survival Project (655-0011). The extent of this procurement is described in the project financial plan.

This determination is based upon a reasonable analysis of the supply and prices of indigenous and shelf item goods and services expected to be required, taking into account comparable delivery items and prices from eligible sources and the implementation schedule of the project.

By: _____
Mark G. Wentling
A.I.D. Representative
USAID/Lome

ABIDJAN 18855 dtd August 26, 1987

5C(1) - COUNTRY CHECKLIST

Listed below are statutory criteria applicable to: (A) FAA funds generally: (B)(1) Development Assistance funds only; or (B)(2) the Economic Support Fund only.

A. GENERAL CRITERIA FOR COUNTRY ELIGIBILITY

1. FY 1987 Continuing Resolution Sec. 526. Has the President certified to the Congress that the government of the recipient country is failing to take adequate measures to prevent narcotic drugs or other controlled substances which are cultivated, produced or processed illicitly, in whole or in part, in such country or transported through such country, from being sold illegally within the jurisdiction of such country to United States Government personnel or their dependents or from entering the United States unlawfully?

No

2. FAA Sec. 481(h). (This provision applies to assistance of any kind provided by grant, sale, loan, lease, credit, guaranty, or insurance, except assistance from the Child Survival Fund or relating to international narcotics control, disaster and refugee relief, or the provision of food or medicine.) If the recipient is a "major illicit drug producing country" (defined as a country producing during a fiscal year at least five metric tons of opium or 500 metric tons of coca or marijuana) or a "major drug-transit country" (defined as a country that is a significant direct source of illicit drugs significantly affecting the United States, through which such drugs are transported, or through which significant sums of drug-related profits are laundered with the knowledge or complicity of the government), has the President in the March 1 International Narcotics Control Strategy Report (INSCR) determined and certified to the Congress (without

Activity is financed from Child Survival fund.

N/A

Annex C

Congressional enactment, within 30 days of continuous session, of a resolution disapproving such a certification), or has the President determined and certified to the Congress on any other date (with enactment by Congress of a resolution approving such certification), that (a) during the previous year the country has cooperated fully with the United States or taken adequate steps on its own to prevent illicit drugs produced or processed in or transported through such country from being transported into the United States, and to prevent and punish drug profit laundering in the country, or that (b) the vital national interests of the United States require the provision of such assistance?

3. Drug Act Sec. 2013. (This section applies to the same categories of assistance subject to the restrictions in FAA Sec. 481(h), above.) If recipient country is a "major illicit drug producing country" or "major drug-transit country" (as defined for the purpose of FAA Sec 481(h)), has the President submitted a report to Congress listing such country as one (a) which, as a matter of government policy, encourages or facilitates the production or distribution of illicit drugs; (b) in which any senior official of the government engages in, encourages, or facilitates the production or distribution of illegal drugs; (c) in which any member of a U.S. Government agency has suffered or been threatened with violence inflicted by or with the complicity of any government officer; or (d) which fails to provide reasonable cooperation to lawful activities of U.S. drug enforcement agents, unless the President has provided the required certification to Congress pertaining to U.S. national interests and the drug control and criminal prosecution efforts of that country? N/A

4. FAA Sec. 620(c). If assistance is to a government, is the government liable as debtor or unconditional guarantor on any debt to a U.S. citizen for goods or services furnished or ordered where (a) such citizen has exhausted available legal remedies and (b) the debt is not denied or contested by such government? No

5. FAA Sec. 620(e)(1). If assistance is to a government, has it (including any government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities? No

6. FAA Secs. 620(a), 620(f), 620D; FY 1987 Continuing Resolution Secs. 512, 560. Is recipient country a Communist country? No
If so, has the President determined that assistance to the country is important to the national interests of the United States? N/A
Will assistance be provided to Angola, Cambodia, Cuba, Iraq, Syria, Vietnam, Libya, or South Yemen? No
Will assistance be provided to Afghanistan without a certification? No

7. FAA Sec. 620(j). Has the country permitted, or failed to take adequate measures to prevent, damage or destruction by mob action of U.S. property? No

8. FAA Sec. 620(l). Has the country failed to enter into an investment guaranty agreement with OPIC? No

9. FAA Sec. 620(o); Fishermen's Protective Act of 1967 (as amended) Sec. 5. (a) Has the country seized, or imposed any penalty or sanction against, any U.S. fishing vessel because of fishing activities in international waters? No
(b) If so, has any deduction required by the Fishermen's Protective Act been made? N/A

10. FAA Sec. 620(q); FY 1987 Continuing Resolution Sec. 518. (a) Has the government of the recipient country been in default for more than six months on interest or principal of any loan to the country under the FAA? (b) Has the country been in default for more than one year on interest or principal on any U.S. loan under a program for which the FY 1987 Continuing Resolution appropriates funds?	No No
11. FAA Sec. 620(s). If contemplated assistance is development loan or from Economic Support Fund, has the Administrator taken into account the percent of the country's budget and amount of the country's foreign exchange or other resources spent on military equipment? (Reference may be made to the annual "Taking Into Consideration" memo: "Yes, taken into account by the Administrator at time of approval of Agency OYB." This approval by the Administrator of the Operational Year Budget can be the basis for an affirmative answer during the fiscal year unless significant changes in circumstances occur.)	N/A
12. FAA Sec. 620(t). Has the country severed diplomatic relations with the United States? If so, have relations been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption?	No N/A
13. FAA Sec. 620(v). What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrearages taken into account by the A.I.D. Administrator in determining the current A.I.D. Operating Year Budget? (Reference may be made to the Taking into Consideration memo.)	Togo's status was taken into account in the Taking into Consideration Memo.
14. FAA Sec. 620A. Has the President determined that the recipient country grants sanctuary from prosecution to any individual or group which has committed an act of international terrorism or otherwise supports international terrorism?	No

15. ISDCA of 1985 Sec. 552(b). Has the Secretary of State determined that the country is a high terrorist threat country after the Secretary of Transportation has determined, pursuant to section 1115(e)(2) of the Federal Aviation Act of 1958, that an airport in the country does not maintain and administer effective security measures? No

16. FAA Sec. 666(b). Does the country object, on the basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. who is present in such country to carry out economic development programs under the FAA? No

17. FAA Secs. 669, 670. Has the country, after August 3, 1977, delivered to any other country or received nuclear enrichment or reprocessing equipment, materials, or technology, without specified arrangements or safeguards, and without special certification by the President? Has it transferred a nuclear explosive device to a non-nuclear weapon state, or if such a state, either received or detonated a nuclear explosive device? (FAA Sec. 620E permits a special waiver of Sec. 669 for Pakistan.) No No

18. FAA Sec. 670. If the country is a non-nuclear weapon state, has it, on or after August 8, 1985, exported (or attempted to export) illegally from the United States any material, equipment, or technology which would contribute significantly to the ability of a country to manufacture a nuclear explosive device? No

19. ISDCA of 1981 Sec. 720. Was the country represented at the Meeting of Ministers of Foreign Affairs and Heads of Delegations of the Non-Aligned Countries to the 36th General Assembly of the U.N. on Sept. 25 and 28, 1981, and failed to disassociate itself from the communique issued? If so, has the President taken it into account? (Reference may be made to the Taking into Consideration memo.)

Togo's voting was taken into account in Taking into Consideration Memo.

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20. FY 1987 Continuing Resolution Sec. 528. Has the recipient country been determined by the President to have engaged in a consistent pattern of opposition to the foreign policy of the United States? No

21. FY 1987 Continuing Resolution Sec. 513. Has the duly elected Head of Government of the country been deposed by military coup or decree? No

B. FUNDING SOURCE CRITERIA FOR COUNTRY ELIGIBILITY

1. Development Assistance Country Criteria

FAA Sec. 116. Has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, can it be demonstrated that contemplated assistance will directly benefit the needy? No / N/A

2. Economic Support Fund Country Criteria

FAA Sec. 502B. Has it been determined that the country has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, has the President found that the country made such significant improvement in its human rights record that furnishing such assistance is in the U.S. national interest? N/A

5C(2) - PROJECT CHECKLIST

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A includes criteria applicable to all projects. Part B applies to projects funded from specific sources only: B(1) applies to all projects funded with Development Assistance; B(2) applies to projects funded from Development Assistance loans; and B(3) applies to projects funded from ESF.

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

A. GENERAL CRITERIA FOR PROJECT

1. FY 1987 Continuing Resolution Sec. 523; FAA Sec. 634A. Describe how authorization and appropriations committees of Senate and House have been or will be notified concerning the project.	Referenced in Africa Bureau FY 1988 CP
2. FAA Sec. 611(a)(1). Prior to obligation in excess of $500,000, will there be (a) engineering, financial or other plans necessary to carry out the assistance, and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?	Yes Yes
3. FAA Sec. 611(a)(2). If legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?	N/A
4. FAA Sec. 611(b); FY 1987 Continuing Resolution Sec. 501. If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.)	N/A

5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed $1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability effectively to maintain and utilize the project?	N/A
6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs.	No
7. FAA Sec. 601(a). Information and conclusions on whether projects will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.	(a) N/A (b) N/A (c) N/A (d) N/A (e) Improves Health delivery services (f) N/A
8. FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).	Project will require U.S. technical assistance contractors and commodities.
9. FAA Secs. 612(b), 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.	Host country participation is stated in the project paper. U.S. does not own excess CFA.
FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?	U.S. does not own excess CFA.

12. FY 1987 Continuing Resolution Sec. 521. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity? N/A

[illegible] Continuing Resolution Sec. 558 (as interpreted by conference report). If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities (a) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (b) in support of research that is intended primarily to benefit U.S. producers? N/A

13. FY 1987 Continuing Resolution Sec. 559. Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel? No

14. FAA Sec. 118(c). Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16? Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (a) stress the importance of conserving and sustainably managing forest resources; (b) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (c) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (d) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (e) help conserve forests which have not yet been degraded, by helping to increase production on lands already cleared or degraded; (f) conserve forested watersheds and rehabilitate those which have been deforested; (g) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (h) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (i) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (j) seek to increase the awareness of

Yes, categorical exclusion approved.
No
(a) N/A
(b) N/A
(c) N/A
(d) N/A
(e) N/A
(f) N/A
(g) N/A
(h) N/A
(i) N/A
(k) N/A

The Project is Health Sector Project without significant environmental impact.

U.S. government agencies and other donors of the immediate and long-term value of tropical forests; and (k) utilize the resources and abilities of all relevant U.S. government agencies?

15. FAA Sec. 119(g)(4)-(6). Will the assistance (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas?

(a) No
(b) No
(c) No
(d) No
This is a Health Sector Support Project.

16. FAA 121(d). If a Sahel project, has a determination been made that the host government has an adequate sysem for accounting for and controlling receipt and expenditure of project funds (either dollars or local currency generated therefrom)?

N/A

17. FY 1987 Continuing Resolution Sec. 532. Is disbursement of the assistance conditioned solely on the basis of the policies of any multilateral institution?

No

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FAA Secs. 102(b), 111, 113, 281(a). Describe extent to which activity will (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and

(a) This project is directed to provide rural poor with benefits of development through access to child survival services, largely promoting better health status for women and children.

insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries.	(b) N/A (c) N/A (d) by providing chil survival services (e) N/A
b. FAA Secs. 103, 103A, 104, 105, 106, 120-21. Does the project fit the criteria for the source of funds (functional account) being used?	Yes. Funding is from child survival accoun
c. FAA Sec. 107. Is emphasis placed on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?	Yes
d. FAA Secs. 110, 124(d). Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?	Recipient country will provide well ove 25% of the cost of th project.
e. FAA Sec. 128(b). If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority?	Yes.

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

The project works through and strengthens existing institutions.

g. FY 1987 Continuing Resolution Sec. 540. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions?

No

Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations?

No

Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?

No

h. FY 1987 Continuing Resolution. Is the assistance being made available to any organization or program which has been determined to support or participate in the management of a program of coercive abortion or involuntary sterilization?

No

If assistance is from the population functional account, are any of the funds to be made available to voluntary family planning projects which do not offer, either directly or through referral to or information about access to, a broad range of family planning methods and services?

No

i. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

Yes

j. FY 1987 Continuing Resolution. How much of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?

An 8(a) set aside is one contracting mechanism being considered.

k. FAA Sec. 118(c)(13). If the assistance will support a program or project significantly affecting tropical forests (including projects involving the planting of exotic plant species), will the program or project (a) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land, and (b) take full account of the environmental impacts of the proposed activities on biological diversity?

N/A

l. FAA Sec. 118(c)(14). Will assistance be used for (a) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; or (b) actions which significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas?

N/A

m. FAA Sec. 118(c)(15). Will assistance be used for (a) activities which would result in the conversion of forest lands to the rearing of livestock; (b) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undegraded forest lands; (c) the colonization of forest lands; or (d) the construction of dams or other water

N/A

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control structures which flood relatively indegraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?

2. Development Assistance Project Criteria (Loans Only)

a. FAA Sec. 122(b). Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest. N/A

b. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest? N/A

c. FY 1987 Continuing Resolution. If for a loan to a private sector institution from funds made available to carry out the provisions of FAA Sections 103 through 106, will loan be provided, to the maximum extent practicable, at or near the prevailing interest rate paid on Treasury obligations of similar maturity at the time of obligating such funds? N/A

d. FAA Sec. 122(b). Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities? N/A

3. Economic Support Fund Project Criteria

a. FAA Sec. 531(a). Will this assistance promote economic and political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of Part I of the FAA? N/A

b. FAA Sec. 531(e). Will this assistance be used for military or paramilitary purposes? N/A

c. ISDCA of 1985 Sec. 207. Will ESF funds be used to finance the construction, operation or maintenance of, or the supplying of fuel for, a nuclear facility? If so, has the President certified that such country is a party to the Treaty on the Non-Proliferation of Nuclear Weapons or the Treaty for the Prohibition of Nuclear Weapons in Latin America (the "Treaty of Tlatelolco"), cooperates fully with the IAEA, and pursues nonproliferation policies consistent with those of the United States? N/A

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

5C(3) - STANDARD ITEM CHECKLIST

Listed below are the statutory items which normally will be covered routinely in those provisions of an assistance agreement dealing with its implementation, or covered in the agreement by imposing limits on certain uses of funds.

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

A. PROCUREMENT

1. FAA Sec. 602(a). Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed?	An 8(a) set-aside is one contracting mechanism being considered.
2. FAA Sec. 604(a). Will all procurement be from the U.S. except as otherwise determined by the President or under delegation from him?	Yes
3. FAA Sec. 604(d). If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company?	N/A
4. FAA Sec. 604(e); ISDCA of 1980 Sec. 705(a). If non-U.S. procurement of agricultural commodity or product thereof is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.)	N/A
5. FAA Sec. 604(g). Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible under Code 941 and which have attained a competitive capability in international markets in one of these areas? (Exception for those	N/A

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countries which receive direct economic assistance under the FAA and permit United States firms to compete for construction or engineering services financed from assistance programs of these countries.)

6. FAA Sec. 603. Is the shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S.-flag commercial vessels to the extent such vessels are available at fair and reasonable rates? No

7. FAA Sec. 621(a). If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? Will the facilities and resources of other Federal agencies be utilized, when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs? Yes

Yes

8. International Air Transportation Fair Competitive Practices Act, 1974. If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available? Yes

9. FY 1987 Continuing Resolution Sec. 504. If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States? Yes

10. FY 1987 Continuing Resolution Sec. 524. If assistance is for consulting service through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)? Yes

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B. CONSTRUCTION

1. FAA Sec. 601(d). If capital (e.g., construction) project, will U.S. engineering and professional services be used?	No, value of construction (not to exceed $100,000) precludes seeking sources outside of Togo.
2. FAA Sec. 611(c). If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable?	Yes
3. FAA Sec. 620(k). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed $100 million (except for productive enterprises in Egypt that were described in the CP), or does assistance have the express approval of Congress?	N/A

C. OTHER RESTRICTIONS

1. FAA Sec. 122(b). If development loan repayable in dollars, is interest rate at least 2 percent per annum during a grace period which is not to exceed ten years, and at least 3 percent per annum thereafter?	N/A
2. FAA Sec. 301(d). If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights?	N/A
3. FAA Sec. 620(h). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries?	Yes

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4. Will arrangements preclude use of financing:

a. FAA Sec. 104(f); FY 1987 Continuing Resolution Secs. 525, 540. (1) To pay for performance of abortions as a method of family planning or to motivate or coerce persons to practice abortions; (2) to pay for performance of involuntary sterilization as method of family planning, or to coerce or provide financial incentive to any person to undergo sterilization; (3) to pay for any biomedical research which relates, in whole or part, to methods or the performance of abortions or involuntary sterilizations as a means of family planning; or (4) to lobby for abortion?	Yes Yes Yes Yes
b. FAA Sec. 483. To make reimburse-bursements, in the form of cash payments, to persons whose illicit drug crops are eradicated?	Yes
c. FAA Sec. 620(g). To compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with a land reform program certified by the President?	Yes
d. FAA Sec. 660. To provide training, advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs?	Yes
e. FAA Sec. 662. For CIA activities?	Yes
f. FAA Sec. 636(i). For purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained?	Yes
g. FY 1987 Continuing Resolution Sec. 503. To pay pensions, annuities, retirement pay, or adjusted service compensation for military personnel?	Yes

h.	FY 1987 Continuing Resolution Sec. 505. To pay U.N. assessments, arrearages or dues?	Yes
i.	FY 1987 Continuing Resolution Sec. 506. To carry out provisions of FAA section 209(d) (transfer of FAA funds to multilateral organizations for lending)?	Yes
j.	FY 1987 Continuing Resolution Sec. 510. To finance the export of nuclear equipment, fuel, or technology?	Yes
k.	FY 1987 Continuing Resolution Sec. 511. For the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights?	Yes
l.	FY 1986 Continuing Resolution Sec. 516. To be used for publicity or propaganda purposes within U.S. not authorized by Congress?	Yes

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IBM/AS.-
MINISTERE DE LA SANTE PUBLIQUE
DES AFFAIRES SOCIALES
ET DE LA CONDITION FEMININE

CABINET

N° 1702/87 /MSP-ASCF

ANNEX D

REPUBLIQUE TOGOLAISE
UNION - PAIX - SOLIDARITE

Lomé, le ..... 19 ....

Le Ministre de la Santé Publique, des Affaires Sociales et de la Condition Féminine

à Monsieur le Représentant de l'USAID

L O M E

Réf. : V/L N° USAID/TOGO/87/206
du 12 Juin 1987

Monsieur le Représentant,

Suite à votre lettre citée en référence relative au projet "Soutien de la Santé pour la survie des Enfants",

j'ai l'honneur de vous informer qu'après avoir pris connaissance des grandes lignes de ce projet, l'élaboration de son programme par l'USAID rencontre notre consentement.

Aussi, je vous saurai gré des dispositions que vous voudriez bien prendre pour sa mise au point dans le délai indiqué.

Vous remerciant pour votre précieuse collaboration, je vous prie d'agréer, Monsieur le Représentant, l'expression de ma considération distinguée.

Aissah AGBETRA.-

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Annex D

Agency for International Development
Lomé, Togo

JUN 12 1987

USAID/Togo/87/206

Subject: Health Sector Support for Child Survival (693-0228) - Project Paper
Reference: USAID/Togo/86/339 letter dated October 16, 1986

Dear Mr. Minister:

This letter is to confirm that the design for a new USAID-financed Child Survival project proposed last October is nearing completion and to officially request the Government of Togo's concurrence to proceed with the project following the general outline below:

1. Improve the Ministry's capacity to deliver Child Survival services in a rational, cost-effective way.

2. Address major constraints to the effective delivery of Child Survival interventions by improving the capacity of the MOH's central level to plan, manage, and coordinate the implementation of its Child Survival program. At the health facility level, it will improve the skills of health workers in Child Survival interventions and their responsiveness in meeting the needs of the rural communities it serves.

3. The project will have two major components. First, the establishment of a Unit will strengthen the MOH's capacity to plan, budget, manage, and coordinate Child Survival-related activities. Second, a Child Survival Community Outreach component will strengthen the rural public health delivery system by improving the quality and accessibility of Child Survival services and increase village-level awareness and demand for these services.

4. The Community Outreach component will have two interrelated subcomponents:

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Annex D

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--A Prefecture Health Education Teams subcomponent to focus on developing improved linkages between rural communities and public health fixed facilities, in all 21 prefectures, by the training of health workers and educating villagers in Child Survival matters. The target of this subcomponent is the estimated 60 percent of the rural population within easy walking distance of a health facility. Provisions are included for the construction of up to two small Child Survival-related demonstration facilities as appropriate.

--A Community Outreach Agents subcomponent to reach the estimated 40 percent of the rural population without ready access to a fixed health facility in the regions of the Plateaux and the Savannes, building upon the socio-sanitary community-based health delivery system in place. This subcomponent will facilitate the delivery of Child Survival services provided by fixed centers, inform villagers of home-administerable Child Survival interventions, and reinforce the other subcomponent's community outreach activities. It will have a demonstration effect which will encourage other donors to develop similar community-based health delivery systems in other regions.

5. The project is not a health delivery activity as such nor does it seek to create new institutions. It does seek, however, to overcome major constraints to the effective delivery of Child Survival services through improvements which are within the capabilities of the MOH.

The proposed level of USAID assistance to the project over four years is $4.5 million, which includes $750,000 in funds remaining in the Rural Water Supply and Sanitation project (693-0210) at the planned termination date of December 31, 1987. The proposed date for execution of the Grant Agreement between the United States Government and the Government of Togo is July, 1987.

USAID/Togo believes the above project outline is consistent with the Government of Togo's development strategies and GOT/USAID understandings reached at meetings held with Ministry staff between April 23 and May 7, 1987. If this proposal meets with the Government's concurrence, we respectfully request that you forward to USAID an official request for AID assistance to elaborate the proposed program. The project documents will be reviewed by the new AID Representative, Mr. Mark Wentling, upon his arrival in Togo on June 22, 1987. Your assistance in expediting this request would be most appreciated.

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USAID is pleased to have this opportunity to continue to assist the Government of Togo in its development efforts in the health sector.

Sincerely,

Barbara D. Howard
Acting AID Representative

His Excellency
Mr. Aissah Agbetra,
Minister of Public Health, Social
Affairs and Women's Condition,
Lomé.

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LOGICAL FRAMEWORK

Togo--Health Sector Support for Child Survival: (693-0228)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS
Goal: To assist the GOT to improve the health status of the rural Togolese population.	Measures of Goal Achievement: -- reduction of infant mortality to less than 75/1000 -- reduction of mortality of children 0-5 years to less than 10/1000 -- optimal allocation and effective use of resources available for CS from oversight and direction of CS Planning and Coordination Unit and its Advisory Board, and from CS Commission's coordination and 'clearing house' efforts.

LOP:	FY 1987-FY1992
LOP Funding:	$4,500,000 (A.I.D.), and CFA equivalent of $2,200,000 (GOT)
Date Prepared:	August 13, 1987

MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
-- Health facility service statistics -- Division of Epidemiology statistics -- Social Affairs survey statistics -- MOH statistics from all Divisions at all administrative levels -- Demographic Health Survey -- World Bank Health Sector records -- Planning and Coordination Unit, Advisory Board, CS Commission reports and minutes -- A.I.D., Other Donor, and PVO reports and documents -- National, regional, and local level audience research.	<u>Assumptions for Achieving Goal Targets</u>: -- the GOT will continue to place a high priority on Child Survival and Development -- the GOT will be increasingly able to support, and committed to supporting, recurrent costs of Child Survival interventions -- the GOT will be increasingly able to solicit donor and private sector support for Child Survival -- the GOT complies with covenants -- Health Center personnel promote Child Survival measures -- Health Centers and other facilities become easily accessible to 100% of the rural Togolese population -- Social Affairs and Sanitation field workers continue active participation on behalf of Child Survival -- Rural clients adapt behavior changes and measures in which they have been instructed for improving child survival.

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS
Purpose: To assist the GOT to plan, manage, and coordinate the delivery of Child Survival services in a rational, cost effective way.	Conditions which will indicate purpose has been achieved: End of Project Status: -- GOT promulgated Child Survival Policy and Strategy Paper priorities, rather than donor preferences, determine Child Survival investments. -- MOH allocates resources available for Child Survival for cost-effectiveness and optimal beneficial impact as a result of annual multi-year planning and budgeting exercise. -- Training for Child Survival designed to address areas of greatest need and to maximize use of training resources pursuant to periodically updated Training Plan. -- MOH able to marshall increasing share of GOT resources for Child Survival by advocating reasoned, statistically-supported recommendations to the Ministries of Plan and Finance, and to the Cabinet. -- MOH elicits coordination, unity of purpose, and conformity of Child Survival activities with its announced Child Survival priorities, and avoids fragmentation and duplication of effort. -- MOH successfully solicits donor and PVO resources for Child Survival activities in accordance with its announced priorities.

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS
	-- MOH central level officers trained in planning and budgeting implement, monitor, and evaluate these processes, and supervise Child Survival coordination on their own. -- MOH field personnel annually implement multi-year planning and budgeting process on their own as directed by Central level. -- "Inventory" of Child Survival activities and available commodities updated every three years. -- MOH coordinates fielding of GOT, donor, and PVO Child Survival service delivery and educational efforts to rural areas according to its announced priorities and strategy in a rational, cost-effective way. -- Uniform Child Survival promotional, educational, and reference materials used nation-wide, effecting consistency and correlation of program messages. -- Sustained mass media effort for Child Survival. -- Teams nation-wide and Community Agents in Plateaux and Savanne use upgraded knowledge and skills to effect increased and effective use of Child Survival measures. -- Health Center-based Public Health staff's public relations are improved, Child Survival promotion techniques are persuasive and educational, and Child Survival service delivery is routinely undertaken and technically correct.

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS
	-- 900,000 Togolese (or one-half of the 60% of the 3 million population near a Health Center) aware and convinced of the benefits of Child Survival measures, able to undertake home-administered measures, and visit Health Centers at least six times each during project (a minimum of 5,400,000 visits) for Center-delivered Child Survival services. About 450,000 visits will be by first-time clients. -- About 650,000 villages in Plateaux and Savanne represented by 800 VDCs exercise advanced capability to undertake a broad range of home-administered Child Survival measures and avail themselves of Health Center services. -- The about 650,000 organized villagers, 120 Community Agents, seven Teams, and Health Center-based Public Health staff in Plateaux and Savanne work collaboratively as an effective network to improve child survival statistics; and infant mortality figures for these communities, if available, are only 75% of those for communities not part of such a collaborative outreach network. -- At least two outreach activities based on this project's outreach networks initiated before project end by GOT, donors, PVOs or others.

MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
-- Minutes and reports of Planning and Coordination Unit, Advisory Board, and Commission. -- GOT (esp. MOH), A.I.D., CCCD, UNICEF, World Bank, WHO, Cathwell, ATBEF and other donor and PVO statistics, reports, and documents. -- Family Health Initiatives II project reports and documentation. -- Annual Child Survival Plans and Budgets. -- Routine reports from health service delivery Centers. -- Follow-up verification of statistical data in the field. --Demographic Health Survey --Infant and Child Mortality Survey	<u>Assumptions for Achieving Purpose:</u> -- GOT continuing commitment to the constituent elements of "Child Survival" -- GOT continues planning, budgeting, and coordination process set in place by this project, with appropriate modifications. -- GOT complies with covenants. -- CCCD, UNICEF, WHO, FHI-II, Cathwell, and the general PVO community collaborate with the project and with each other effectively and in a timely manner. -- Instruction, technologies, and improved practices introduced are appropriate for and adopted by the various target audiences. -- No serious socio-cultural, political, or economic roadblocks to change/modification. -- USG provides sifficient funding to support project activities at indicated levels for project duration. -- Women continue to be able to take full advantage of project benefits.

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

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

MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
	Assumptions for Achieving Outputs:
-- project evaluations	-- Child Survival Planning and Coordination Unit reports to Minister of Health.
-- Projects audits	-- Advisory Board and Commission convene at least according to schedule with quorums present.
-- Minutes and reports of Planning and Coordination Unit, Advisory Board, and Commission	-- GOT seconds sufficient high level, appropriately qualified officials for full-time service at the Center, and for full and part-time service elsewhere.
-- Performance evaluation reports of Child Survival Officers	-- MOH personnel released from ordinary official duties for sufficient periods for effective instruction.
-- Contractor reports	-- Prefecture and regional level budget materials submitted according to Unit-prescribed schedule.
	-- GOT retains Teams' and Agents' systems during project.
-- Consultant reports	Prefecture Health Education Teams and Community Agents made available by GOT for project service. Teams and Agents are qualified to execute envisaged project responsibilities satisfactorily.
-- Scheduled reports of project personnel at all levels	-- CCCD, UNICEF, WHO, FHI-II, the PVO community, and appropriate MOH entities cooperate with this project and with each other to furnish consistent, correlating instruction and pedogogical aids, to render Child Survival interventions technically sound, and to increase substantially the quality and quantity of Child Survival service delivery.

MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
-- GOT (esp. MOH), CCCD, UNICEF, FHI-II, World Bank, other donor and PVO statistics, reports, and documents -- Site visits, audience research, and associated reports	-- MOH makes available health service delivery facilities (Health Centers) and their staff for project activities. -- Appropriate technical assistance personnel identified and provided on schedule to meet project needs. -- Required commodities, equipment, and pedagogical aids available on a timely basis from eligible sources. -- Instruction, training, and technologies are appropriate and sufficient to attain outputs in project setting. -- Medical training institutions integrate Child Survival subjects and treatment into their curricula. -- Women are able to take full advantage of project benefits, including, but not limited to voluntary birth spacing. -- Management of and accounting for local currency advances during period before LTTA arrival conforms to A.I.D. Payment Verification Policy mandates.

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

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

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

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

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS
Inputs: I. A.I.D. A. Technical Assistance 1) Long-term a) Health Planner (36 months) b) IEC Specialist (36 months) c) Expatriate PSC Agents' Coordinator (36 months) d) Togolese PSC Teams' Coordinator (36 months) 2) Short-term (up to 16 months) in appropriate disciplines as required, especially in training needs assessment and plan preparation, Child Survival technical specialties, instructional materials for illiterate audiences, recurrent cost analysis and sustainability enhancement, evaluation, and audit. B. Support to Unit Coordinator C. In-country human resources upgrading: Planning and budgeting training. Adult health education, interpersonal and community relations, Child Survival substantive overview, discrete topic, and promotional methods instruction. D. Commodities (expendable and non-expendable for operations, and pedagogical aids)	Implementation Target (type and quality): See Financial Plan, Budget Worksheets, and Implementation Plan, of the Project Paper

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS
E. Vehicles	
F. Motorcycles	
G. Construction	
H. Operational Costs	
II. GOSL	
A. Personnel (salaries)	
B. Office Space	
C. MOH rural Public Health and Social Affairs facilities	
D. Training/conference facilities in rural areas	
E. Operating Costs	
F. Expendable supplies	

MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
-- A.I.D., MOH, and contractor project records. -- CCCD, UNICEF, FHI-II, and other project participants' project-related records. -- Vouchers. -- PIO/Ts, PIO/Cs, PIO/Ps, and local currency advance requests and liquidation documentation.	Assumptions for Providing Inputs: -- A.I.D. and GOT proposed funding levels approved by their respective governments and disbursements made on a timely basis. -- GOT meets all conditions precedent in a timely manner. -- Appropriate technical assistance personnel, training and resources from collaborating entities identified and provided to meet project needs.

ANNEX F

AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D.C. 20523

ACTION MEMORANDUM FOR THE ACTING ASSISTANT ADMINISTRATOR FOR AFRICA

FROM: Carol Peasley, AFR/PD

SUBJECT: Togo - Health Sector Support for Child Survival Project 693-0228: Vehicle Source/Origin Waiver

I. PROBLEM

A source/origin waiver from A.I.D. Geographic Code 000 (U.S. Only) to A.I.D. Geographic Code 935 (Special Free World) is requested to permit the purchase of the below listed vehicles and spare parts under the planned Togo Health Sector Support for Child Survival Project, 693-0228. The project is scheduled to be authorized in July 1987.

II. BACKGROUND

A.	COOPERATING COUNTRY:	Togo
B.	GEOGRAPHIC CODE:	941 and Host Country
C.	DESCRIPTION OF COMMODITIES:	Two heavy duty suspension sedans, one light-duty sedan, one heavy-duty-suspension station wagon, one four-wheel drive off-road vehicle, plus spare parts.
D.	MANUFACTURER:	Most probably Peugeot, Toyota, Datsun, or Daihatsu.
E.	APPROXIMATE VALUE:	$84,000
F.	PROBABLE SOURCE/ORIGIN:	Togo, France, and/or Japan

III. DISCUSSION

The Togo Health Sector Support for Child Survival Project presently being designed, will develop two essential prerequisites for improving the quality, availability, and delivery of child survival services in rural Togo. The first prerequisite is a planning, budgeting, and management capability within the Ministry of Public Health, Social Affairs and Women's Condition (MOH). To establish this capability a child survival planning and coordination unit will be created within the MOH.

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The requested vehicles will constitute the unit's motor pool for use by the unit's staff to travel extensively throughout Togo and provide instruction in the preparation of standardized plans and budgets. The second prerequisite is the establishment of a "rural network for child survival" which will encompass all MOH rural health facilities nationwide and remote villages in the Plateaux and Savanes regions. The undertaking, monitoring, and supervision of these network-related activities will require frequent travel by unit staff to remote regions over rough terrain. Frequent preventive maintenance and post-field trip repairs will be necessary for project implementation success. Down-time due to insufficient repair facilities, lack of spare parts, or both, cannot be afforded -- especially in a project such as this with a relatively short four year period to implement numerous activities.

At present, no U.S. vehicle manufacturer is represented in Togo. There is no distribution network of spare parts for U.S.-made vehicles, nor is there a maintenance and repair capability for them. Local mechanics are totally unfamiliar with U.S. brands. In contrast, the French and Japanese vehicle manufacturers have established dealerships, and their spare parts and distribution networks reach even the remotest regions of Togo. Local mechanics are experienced in maintaining and repairing vehicles of these manufacturers

IV. JUSTIFICATION

Section 636(i) of the Foreign Assistance Act of 1961, as amended, requires that all motor vehicles, to be eligible for A.I.D.-financed procurement, must be manufactured in the United States unless special circumstances permit a waiver. In accordance with A.I.D. Handbook 1 Supplement B, Section 4C2d(1)(b), special circumstances exist if there is a present or projected lack of adequate service facilities and supply of spare parts for U.S. manufactured vehicles. Delegation of Authority No. 405 gives the Assistant Administrators authority to waive source/origin requirements in this instance.

The information presented above establishes that vehicles with spare parts availability and with reliable maintenance and repair facilities in remote areas of Togo are essential to successful implementation of this project. It further establishes that there is no present or projected distribution network of spare parts for U.S.-made vehicles in Togo.

V. RECOMMENDATION

For the reasons set forth above, it is recommended that you:

(1) Conclude that special circumstances exist which merit a waiver of Section 636(i) of the Foreign Assistance Act of 1961, as amended;

(2) Waive the source/origin requirements set forth in A.I.D. Handbook 1, Supplement B, to permit procurement of the above-identified vehicles from countries included in the A.I.D. Geographic Code 935; and

(3) Certify that, in accordance with Delegation Of Authority 405, exclusion of procurement of these vehicles from the Free World countries other than the cooperating country and countries included in A.I.D. Geographic Code 941 would seriously impede the attainment of U.S. foreign policy objectives and the objectives of the Foreign Assistance Program.

Approved: _____

Disapproved: _____

Date: July 1, 87

CLEARANCES:

AFR/PD/CCWAP:JHradsky		Date	6/29/87
AFR/CCWA:MMeares	(draft)	Date	6/17/87
AFR/DP/PAB:DWilson	(draft)	Date	6/17/87
GC/AFR:PJohnson	(draft)	Date	6/17/87
GC/CM:MRiedy	(draft)	Date	6/16/87
SER/OP/COMS:RGreen	(draft)	Date	6/18/87
DAA/AFR:ELSaiers		Date	7/1/87
AFR/CONT:RKing		Date	6-29-87

DRAFTED: DLeong:AFR/PD/CCWAP:647-9062:6/19/87:AFS:3306K

104

(3) ACTION: REDSO INFO: WAAC ECON/POL

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DE RUEHC #6115 1982204
ZNR UUUUU ZZH
O 07E200Z JUL 87
FM SECSTATE WASHDC
INFO AMEMBASSY ABIDJAN IMMEDIATE 5414
BT
UNCLAS STATE 206115

LOC: 307 418
09 JUL 87 2206
CN: 38037
CHRG: AID
DIST: AIDL

AIDAC

FOLLOWING STATE 206115 DTD JUL 03 SENT ACTION LOME IS HEREBY REPEATED FOR UR INFO:
QUOTE:
UNCLAS STATE 206115

AIDAC

E.O. 12356: N/A

SUBJECT: TOGO HEALTH SECTOR SUPPORT FOR CHILD SURVIVAL PROJECT 693-0228: VEHICLE SOURCE/ORIGIN WAIVER

AA/AFR APPROVED SUBJECT WAIVER JULY 1, 1987. COPIES WILL BE POUCHED TO MISSION ASAP. SHULTZ
UNQUOTE SHULTZ
BT
#6115

NNNN

Action PDRI
Info PDAS
ROP
Due Date 7/09
Action Taken

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INITIAL ENVIRONMENTAL EXAMINATION

UNCLASSIFIED STATE 178111

ACTION: AID INFO: AMB DCM CHRON

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O RUFHPC
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O R 102259Z JUN 87
FM SECSTATE WASHDC
TO RUFHPC/AMEMBASSY LOME IMMEDIATE 9816
INFO RUEHAB/AMEMBASSY ABIDJAN 4698
BT
UNCLAS STATE 178111

LOC: 135 2
11 JUN 87 225
CN: 17952
CHRG: AID
DIST: AID

AIDAC

E.O. 12356: N/A
TAGS:
SUBJECT: TOGO HEALTH SECTOR PLANNING (693-0228)

REF: LOME 03299

IEE APPROVED FOR SUBJECT PROJECT 8/22/86. COPY POUCHED. WHITEHEAD
BT
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UNCLASSIFIED STATE 178111

Annex G

BEST AVAILABLE COPY

UNCLASSIFIED

014878 0228

ACTION: AID INFO: AMB DCM CHRON

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PP RUFHPC
DE RUFEAJ #4878 183[illegible]28
ZNR UUUUU ZZE
P [illegible]Z JUL 87
FM AMEMBASSY ABIDJAN
TO RUFHPC/SECSTATE WASHDC PRIORITY 9343
INFO RUFHPC/AMEMBASSY LOME [illegible]
BT
UNCLAS ABIDJAN 14878

LOC: [illegible]
[illegible] JUL [illegible]
CHRG: AID
DIST: [illegible]

712

AIDAC

SECSTATE FOR AFR/TR, R. BOYD

F.O. 12356 N/A
SUBJECT: IEE REVISION, TOGO HEALTH SECTOR SUPPORT FOR CHILD SURVIVAL (683-0228) PROJECT

REF: STATE 178111

1. IEE FOR SUBJECT PROJECT WAS DRAFTED 13 MARCH 1986 AND APPROVED BY AID/W ON 11 JUNE 1987 PER REFTEL. IN THE INTERIM, A MINOR CONSTRUCTION COMPONENT CONSISTING OF CONSTRUCTION OF TWO SMALL CHILD SURVIVAL OR FAMILY WELFARE CENTERS HAS BEEN ADDED TO THE PROJECT. THE SPECIFIC LOCATIONS OF THESE CENTERS, AND WHETHER THEY WILL BE CONSTRUCTED INDEPENDENTLY OR AS WINGS TO EXISTING FACILITIES, HAS YET TO BE DETERMINED. THEY WILL, HOWEVER, BE OF LIMITED SIZE AND WILL BE BUILT ON SITES CHARACTERIZED BY SUBSTANTIAL PRE-EXISTING HUMAN DISTURBANCE OF THE NATURAL ENVIRONMENT. IN THE OPINION OF THE REGIONAL ENVIRONMENTAL OFFICER (REO), SIGNIFICANT ADVERSE ENVIRONMENTAL IMPACT IS UNLIKELY TO RESULT FROM CONSTRUCTION OF THESE TWO SMALL FACILITIES AND THE COMPONENT IS THERFORE RECOMMENDED FOR NEGATIVE DETERMINATION PURSUANT TO THE PROVISIONS OF 22 CFR 216.

2. REO REQUESTS BUREAU ENVIRONMENTAL OFFICER (BEO) CONCURRENCE AND GC/AFR CLEARANCE FOR THIS MINOR IEE REVISION FOR SUBJECT PROJECT, AND THAT CONCURRENCE/CLEARANCE BE CABLED AT EARLIEST OPPORTUNITY.

3. WE APPRECIATE YOUR ASSISTANCE. KUX
BT
#4878

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Annex G

UNCLASSIFIED ABIDJAN 014878

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UNCLASSIFIED STATE 220431

0228

ACTION: AID INFO: AMB DCM

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PP RUEHPC
DE RUEHC #0431 1981827
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TO AMEMBASSY LOME PRIORITY 0127
BT
UNCLAS STATE 220431

LOC: 169 054
17 JUL 87 2159
CN: 22341
CHRG: AID
DIST: AID

AIDAC

E.O. 12356: N/A

SUBJECT: TOGO HEALTH SECTOR SUPPORT FOR CHILD SURVIVAL PROJECT CN

REF: LOME 4110

1. SUBJECT CN WAS SENT TO THE HILL ON JULY 10, 1987. IF THERE ARE NO OBJECTIONS, OBLIGATION MAY BE INCURRED ON JULY 25, 1987. WILL ADVISE.

2. COPY OF CN POUCHED TO MISSION 16 JULY 1987.

3. FYI. OBLIGATION CAN NOT BE INCURRED UNTIL BUDGET ALLOWANCE IS RECEIVED. END FYI.

4. BUDGET ALLOWANCE IN PROCESS FOR THIS PROJECT.
SHULTZ
BT
#0431

NNNN

UNCLASSIFIED

USAID/TOGO - LOME
DATE OF TRANSMISSION 7/18
IN OFFICE DATE

Distribution: STATE 220431	Action/ Subject	Info/ Ref	Comm
MW			
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ACTION TAKEN: M 100
DATE 7/20
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ANNEX I

PROJECT ANALYSES

1. INSTITUTIONAL SOUNDNESS AND ADMINISTRATIVE FEASIBILITY

The activities and interactions discussed herein already have received attention in the Detailed Project Description and the Implementation Plan. This analysis will test the capacity of each participating entity to perform its intended functions, and the adequacy of the project's management resources and processes to combine participating entities' contributions to realize the project purpose within the envisioned time.

One of the insufficiencies this project addresses is the widely acknowledged lack of planning, management, and budgeting capacity within the Implementing Agency, the MOH. This insufficiency is being addressed by the creation of a Child Survival Planning and Coordination Unit within the MOH, independent of the three Directorates but under their policy guidance, reporting directly to the Minister of Health. Accordingly, the current Minister of Health is not being assigned primary responsibility for managing project activities: the Unit has this assignment.

The Unit, with the envisioned instituitonal placement and the envisioned staffing, strengthened through long-term technical assistance personnel, will be capable of managing project activities and, at the end of the project, will provide services viewed as indispensible by the MOH, rendering the MOH, through it or a similar entity, able to continue project activities. It is anticipated that the Unit Director will be seconded from the Ministry of Plan, but financed by the Project, for the life of the project. However, the Unit's Coordinators are being provided by the MOH, preferably one from the Directorate of Public Health and one from the Directorate of Social Affairs, so that by the end of the project there will be at least two senior MOH officials with extensive in-service training and experience in planning, budgeting, and coordinated management. Their new competence will be applied initially to the conduct of Child Survival activities, but it is expected that eventually their management skills will be applied to the full range of their respective Directorates' concerns. The Unit's Coordinators will acquire skills of a high technical standard under the guidance of the Health Planner and the Unit Director. These practical skills will be further strengthened through the provision of a modest amount of off-shore training and by two in-country management seminars for a better understanding of the principles of modern management and planning.

Sufficient training and reinforcement has been provided to assure the administrative feasibility of the early planning and budget excercises. Participating MOH officials will receive intensive initial training, from which they will take away standardized forms, detailed procedural instructions, uniform costing indices, and a comprehensive reference manual. A Unit member or one of the technical advisors will provide on-site personalized assistance upon request during the first planning

and budget exercise. The technical advisors will be in-country during the next two scheduled exercises to refine implementation improve reporting procedures.

The Health Centers Support Component's activities also are being provided with sufficient, appropriate resources for administrative soundness. The 21 Prefecture Health Education Teams, comprising two health officer Coordinators and a Peace Corps Volunteer is a MOH initiative being undertaken because the MOH itself realizes the importance of decentralizing health education. Because it is not a superimposed effort, but one for which the MOH is seeking resources and expertise, project resources are likely to be put to high, effective use. Teams have been and will be provided with intensive training to assure they understand their function and that they are well-versed in Child Survival. Their members are technically qualified to execute the responsibilities assigned to them under this project because they are drawn from the ranks of public health workers who were based at Health Centers and because they have medical education and experience. The Teams can be expected to serve beyond this project for two reasons: first, because they are part of a MOH initiative; and, second, because the planning and budget exercise will demonstrate their cost effective, productive impact on the quality and quantity of health service delivery.

Regarding the Outreach Network Component, the Community Agents drawn from the ranks of Social Affairs and Sanitation Agents, with extensive experience in mobilization of communities in health related activities, represent an institutional base from which Child Survival activities can be administered. The existing community-based health delivery system in the two target regions is expected to represent ready access to communities for the prefecture Teams which is not generally available in the other regions. It should be emphasized that Agents are not being asked to undertake technically sophisticated health interventions, only to forge stronger linkages between the communities they serve and health facilities, and to undertake health related activities not normally provided by Health Centers, e.g., instruction in home-administered Child Survival measures, adult literacy using health-related teaching materials, "clean village" campaigns, and education campaigns for community action against guinea worm. Under the project the Agents will continue to be provided motorcycles and related support to reach their clientele. Funds will be provided for community mobilization and education efforts relating to vaccination, ORT, and malaria treatment. The mobilization/instructional process to be used has proved effective in prior health development efforts in Togo. After this project, the effectiveness of these Agents (demonstrated by the planning and budgeting process) will act as an incentive to the MOH to retain them under the MOH budget to continue community health mobilization.

The project's dual focus on planning/budgeting/coordination on the one hand, and on rural Health Center strengthening and community outreach on the other, is itself administratively and institutionally sound. The first focus will establish a MOH management capability which will render the MOH a strong institution for the purpose of implementing Child Survival activities by the end of the project. The second focus is essential to laying the groundwork for expanded and improved rural

service delivery for which the planning and coordination efforts are being undertaken. Making available these services without informing communities of their availability or in an unacceptable manner will mean low client use and unimproved health status.

2. TECHNICAL

The techniques of planning, budgeting, and coordination being taught under this project have been taught before to other groups in Togo, e.g., under the AID-financed water and sanitation project where planning and budgeting is practiced with sustained satisfactory results. There is reason to expect success with this project's venture as phased training is being provided to moderately sized groups of officials similarly situated in the MOH. Constituents of these groups will have similar interests and similar roles to play in the planning process. They will be taught by experienced technical advisors led by the Health Planner and the Unit Director, also a trained planner, who have instructed similar groups in developing countries in these techniques before. The teaching materials, standardized forms, and related materials will be designed in Togo in consultation with MOH and MOP personnel and extensively field-tested to assure relevance to and appropriateness for the Togolese context. There will be emphasis in standardizing the teaching curricula and the forms to be filled out and on assuring that procedural instructions as to what information is to be provided on the forms are clear. Only in this way can comparability of information be assured.

It is foreseen that the planning and budgeting cycle will proceed as follows. Training will begin at the Central level with three day sessions for about 20 senior level officials (Directorate and Division Chiefs) and two additional days for about 20 senior operational staff who will have attended the first three days with these chiefs. Then a two day session will be held in Lome for about 15 regional officials. Shortly thereafter four day sessions will be held in each of the five regions for the 21 Chief Doctors in the prefectures and the Prefecture Health Education Team leader (total of 42) plus a small number of other appropriate personnel depending upon local operations.

Foreseeably, there could be a significant interval between this tiered training and the official directive to begin the planning and budgeting exercise. It is reasonable to expect that the exercise will proceed satisfactorily, however, because trainees will have been given standardized forms to submit to the Unit, and also supplied with manuals and procedural instructions replete with directions on completing the forms and executing other required activities. It is anticipated that a substantial number of participants in the process will need personal assistance, especially during the first implementation of the exercise, and Togolese and expatriate Unit personnel will be on call to travel where help is required.

Once adequately completed forms have been submitted to the Unit by the 21 prefectures, technical assistance personnel will guide their counterparts in organizing and analyzing the information, reconciling discrepancies between demands and resources, and ranking the demands by priority. The next stage will be a negotiating dialogue among the

Ministries of Health, Plan, and Finance, during which Health will set forth its Child Survival programmatic recommendations and attempt to secure more resources for Child Survival activities. The resulting compromises and accomodations will be used to formulate final recommendations to be passed to higher levels for decision. After the decision is published, MOH participants in the planning budgeting exercise will be convened for one day of reinforcement training involving recapitulation of how the process operated, empirical explanation of various actors contributed to the ultimate decision, and suggestions for improving the next year's performance. There will be two recapitulation exercises, one for national and one for regional level personnel, and one session in each region for prefecture-level personnel in that region.

The training, reinforcement assistance, and recapitulation instructions, and the guided repetition of the cycle three times throughout the life of the project will institutionalize the undertaking of the exercise for Child Survival activities. Demonstration of the effectiveness of planning, budgeting, and coordination for the important group of health officials will encourage their application to the full range of MOH concerns. By the end of the project sufficient numbers of MOH personnel will have the requisite training and experience in the relevant techniques to effect this broader application.

The strengthening of Health Centers and establishment of Child Survival outreach networks also is technically feasible in Togo if undertaken as discussed in the Detailed Project Description, i.e., using in-place personnel and structures which have proven abilities and a high degree of GOT support. Under the Health Centers Support Component, Teams will not be trained in esoteric technologies but rather instructed in how to assure appreciation and increased use of technologies of proven effectiveness in rural areas of developing countries. As trainers of trainers they also will be trained in the deliberate, phased transfer of their instructional role to Public Health personnel who have the technical competence to assume this role. The Outreach Network Component has had reasonable success in introducing home-prepared ORT. Similar success can be expected for the planned vaccination and malaria activities. Community Agents have successfully undertaken adult literacy with health related materials, guinea worm control, and fund raising for health services programs. Their current professional background equips them for informing communities about Child Survival benefits and about what can be done to obtain them. Community Agents will explore self-help measures, similar to already working village collection schemes for pump repair, which will permit villages to organize for availing themselves of Health Center services.

The above discussion establishes that the training content and methodologies, and the techniques and technologies envisioned for project use are appropriate to the Togolese context and will be predictably effective in contributing to achievement of the project purpose.

3. ECONOMIC

This project seeks to assist the GOT to plan and deliver Child Survival services in a rational and cost-effective way by: improvement of the MOH's capacity to plan, finance and coordinate Child Survival

activities; and inform rural populations of Child Survival technologies available from a more responsive public health delivery system. Long range benefits of such a project are difficult to measure and the economic analysis will study the relative effectiveness of the different components, largely in qualitative terms.

The analysis views the public health delivery system in the terms of inadequate supply of services (misallocation of resources, inadequately trained staff in cost-effective Child Survival techniques, etc.) and poor demand for those services that are available (inadequate information about health problems and treatment, perceived unresponsive public health system, etc.). It takes into account Togo's financial limitations by basing health delivery on strengthening existing structures, with the exception of the planning/budget unit, and limiting significant recurrent cost inputs to improving the mobility of field health agents (motorcycles and related costs). Cost of commodities to support delivery of health services (vaccines, chloroquine, etc.) will be provided outside the project. The analysis of the two major project components follows:

a. Planning and Budgeting Component

This component seeks to improve the allocation of MOH's resources, not only for Child Survival activities but public health services in general. A total of 105 persons will be trained in planning and budgeting at an average cost of $250 per person. This includes technical advisory services devoted to this component but not off-shore training which is programmed for wider level of understanding of the principals of planning and administration.

Direct benefits identified under this component include:

-- MOH personnel (105) trained and practicing proper planning and budgeting procedures based upon a Child Survival strategy;

-- improved resource allocations as trained officials will be better able to identify needs, determine cost of resources needed, and present reasonable budgets which are more likely to obtain budget allocations;

-- improved supply inventory systems in the field so commodity needs are more accurately estimated. This will lead to fewer shortages in the field and closer inventory control at the central level; and

-- improved donor coordination which will lead to increased awareness of activities of others to ensure resources are allocated for priority health problems and effeciently administered.

Indirect benefits of this component include:

-- increased proportion of the national budget allocated to the health sector due to improved ability of MOH to plan and manage funds. Between 1983 and 1986, the health budget fell by nearly 11 percent in real terms, while the investment portion of the health budget fell by nearly 41 percent. In the same period, real per capita expenditures fell by nearly 19 percent. Unrealistic budget presentations and perceived poor MOH administration of resources that are provided are reasons given

for the decline of health's share in the national budget. It is anticipated improvements in the credibility of the MOH's annual budget and planning process will bring back the health share of the planned GOT budget to the mid-1980 levels of 7.0 percent as compared to 5.77 percent in 1986.

-- increased cooperation between donors and MOH, along with better administration, will result in higher levels of donor assistance directed to high priority Child Survival programs.

There are no reasonable alternatives readily available for improving the budget and planning capacity of the public health system in a short period of time. For example, MOH personnel could be sent to the U.S. to learn planning and budgeting, but it is unrealistic to expect sufficient numbers of required staff would be available for the required time and costs would be prohibitive. A limited number of MOH officials, key to the budget/planning process will be provided short- to long-term training in these fields, but only in numbers sufficient to provide a core of trained staff needed to provide professional expertise in the MOH.

In the short time allocated to develop a capacity to plan and budget Child Survival activities on a national scale, the project approach of on-the-job training in the field, using well prepared instructional and standard reporting materials, and similar on-the-job training, supplemented with limited, off-shore basic theory and professional training, for the central level will produce the essence of such a system within the existing structure at a minimum cost due to disruption.

b. Health Centers Support Component and Outreach Network Component

These components address the problem of weak demand and inadequate supply in the delivery of Child Survival services.

Each of the 21 prefectures are serviced by a Prefecture Health Education Team consisting of a Health Coordinator, an Assistant Coordinator, and a Peace Corps Volunteer. The Teams are expected to better inform communities of Child Survival-related health problems and how they can be addressed, improve relationships between the communities and Health Centers, and train health workers in Child Survival techniques and community relations.

In two regions where community-based health delivery systems are in place, already trained Agents will be used to extend Child Survival techniques (vaccination, ORT and Malaria control) to villages and collaborate with the Teams. These Agents will generally promote and inform village populations of Child Survival techniques available at Health Centers, and, to a limited extent, instruct in the practice of home-prepared techniques.

(3) Benefits

-- The population will be informed of Child Survival-related techniques, will have more confidence in the delivery of these services, and will avail themselves of such services at a rate of 50 percent higher than the current rate by the end of the project.

-- The remote area population in the two target regions is estimated to number 250,000 persons. This group will have access to home-prepared techniques in major Child Survival interventions of ORT and malaria control, a better knowledge of why and where to seek more sophisticated health care, and better access to Health Centers.

-- Approximately 300 Health Centers will be providing Child Survival-related services in at least the three interventions of vaccination, ORT, and malaria control in an effective manner responsive to community needs.

-- Approximately 1,300 health workers trained in basic IEC, community development and Child Survival skills, and deliverying such services.

(4) Alternatives

There are two approaches to an analysis of this component:

-- one is to extend the outreach of the Health Centers into remote regions. Under the EPI program this was attempted with each prefecture provided a mobile vaccination unit, but discarded due to expense and logistical problems in maintaining such a system. The approach in use now is to increase the number of vaccination posts, at Health Centers, and furnish bicycles to increase community outreach capabilities. The present system is within the capabilities of the MOH, but has only limited outreach.

-- The second option is to place the burden on the population to use the facilities of Health Centers. This approach has the advantage of the community sharing in the cost of its health care and lessens the burden on the government of providing it. However, it assumes the population is aware of a particular health problem and the need for treatment, and a belief that people can be adequately treated at a fixed health center to offset the cost of reaching the facility. The existing community-based health delivery system in two regions has demonstrated that communities are willing to pay for the cost of maintaining a potable water source (generally a pump set) for a source of clean water. Properly informed, it is believed the same villagers would be willing to pay the cost of treatment of Child Survival-related illnesses. Another example of community cost sharing for health services are some successful examples of village pharmacies, community construction of health facilities and staffing with first-aid personnel, etc. These tend to be isolated incidences or pilot projects, but indicate cost-sharing of health care is an option (consistent with official GOT policy). Costs for access to fixed centers is relatively modest (about 50 cents for a 20 kilometer trip or about the average distance between a remote village and a Health Center), and this cost could be lessened by the community sending a group for vaccinations for example. In this case, the issue is whether the use of Community Agents is the most cost-effective means available to achieve better Child Survival services for communities.

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(5) Costs

The major cost for the Community Agents system is the mobility element (motorcycles and related expenses), and it is a recurrent one. However, any alternative to the existing system of Community Agents would incur the same costs, as roads are poor and distance long, making bicycles an unrealistic option. Estimates range from 3-5 kilometers as the maximum range for effective health coverage from a Health Center by health agents. Other donors, such as the Volontaires du Progres, have chosen to work directly with Health Centers to provide better access to services, such as village pharmacies, with high investments in expatriate assistance (two French volunteers per prefecture in two prefectures have established 40 functioning village pharmacies) due to the sustained effort needed to mobilize communities (the French volunteers estimate it takes 6-12 months until a village pharmacy is operating effectively). The approach taken by this project is to use existing MOH systems for mobilizing distant communities, provide appropriate technical training and oversight for mobilization of communities in specific Child Survival campaigns, and seek reasonable solutions for meeting the cost of mobility.

The Prefecture Health Education Teams subcomponent is difficult to analyze as it is a relatively new attempt to improve the community's access to Child Survival services available at Health Centers. The need for better community access to health facilities has been expressed in public by the President. The health education team approach began in 1985, but never really began to function until 1986 when Peace Corps support began (PCVs at SNES, staff training, teaching materials and other support) in nine prefectures. Current plans are to have 16 prefectures participating in the program by September 1987 and all 21 a year later -- with a PCV becoming a full-time member of the team on the same schedule. A major obstacle has been a lack of mobility (only the five Teams collaborating with Community Agents in the five pilot prefectures in the project's target regions are provided motorcycles at present). The economic justification for the provision of motorcycles is the same as that for providing motorcycles to Community Agents. Distances are shorter for the Teams but coverage is extended to more communities rather than a selected few. In addition, early reports on the effectiveness of collaboration between the Teams and Agents have been very positive. To foster the collaboration of Teams and Agents it is important that both be similarly supported, including motorcycles and related expenses. To do otherwise would be to encourage a differentiation between the two when goals are much the same and mutually reinforcing. In practice, SNES has strived to encourage multi-donor support for its programs, e.g., CCCD, Peace Corps, and UNICEF have been major supporters of extension of health education into communities. This collaboration is expected to continue and the most important element of this project's support is expected to be technical advisory services in IEC and the coordination role played by the Unit in obtaining a broad range of assistance for the program. Direct project support, beyond institutional strengthening, is more of financing of immediate needs as opposed to sustained support for the program.

This project meets the criteria of cost effectiveness by supporting institutional mechanisms with, for the very large part, required resources already in place or within the capability of the MOH to sustain.

4. FINANCIAL

A. Methods of Implementation and Financing

Project Element	Implementation	Financing	Amount
Technical Assistance			
Major TA Contract	AID Direct Contract	Dir. Reim.	3,296
PSC	AID Direct Contract	Dir. Reim.	330
Training (US MAs & in-country Mgmg.Seminars)	AID Direct Contract	Dir. Reim.	280
Vehicles	AID Direct Contract	Dir. Reim.	84
Commodities	AID Direct Contract	Dir. Reim.	15
Construction	AID Direct Contract	Dir. Reim.	100
Local Op. Exps.	Host Country Coord. Unit	Dir. PT/Cash Advance	155
Evaluation	AID Direct Contract	Dir. Reim.	175
Audit	AID Direct Contract	Dir. Reim.	30
Contingency	To be determined	To be determined	35

B. Analysis of Financing Methods

All financing as proposed above for the project utilizes the preferred methods of financing.

C. Assessment of Contracting and Financial Management Capability

No host country contracting by the Ministry of Health is anticipated. Therefore, no host country contracting assessment will be undertaken.

It also has been determined that an adequate system of accounting and control, which already satisfies the requirements of the Payment Verification Policy, will be used by this project, and that accordingly an assessment of host country financial management capability will not be required. This determination is based on the West Africa Accounting Center's familiarity with the successfully operating accounting system currently used by the Rural Water Supply and Sanitation Project and on the fact that the GOT must agree in writing to use this system and the personnel now operating it as a condition precedent to disbursements to finance local costs. GOT management of local costs is limited to the period before arrival in Togo for contractor-fielded Long-term technical assistance personnel. During this time, periodic advances will be made

to the Unit. In 1984, the public accounting firm of Akintola Williams performed extensive systems work and training to bring that project's accounting system into compliance with the requirements of the Payment Verification Policy and to assure that project accounting personnel were implementing the system in accordance with the Policy's guidelines. The system and its personnel have been working satisfactorily since then and the Mission has been uncompromising in assuring continued compliance.

D. Audit Requirements

Provision is made in the budget to finance an audit. The audit will be through a contract for a non-federal audit under the auspices of the Inspector General.

E. Controller Statement

This project paper has been reviewed by personnel of the West Africa Accounting Center. The considerations of payment verification have been adequately addressed and the Controller at REDSO/WAAC approves the methods of implementation and financing contained therein.

5. SOCIAL SOUNDNESS

This project has numerous sociocultural strengths. First, it has been designed to take into account the need of the primary groups of envisioned direct beneficiaries. Second, it has been designed to assure intense, continuing beneficiary participation. The Unit is one mechanism for assuring this participation. The two community outreach groups are another. The strengthening of existing institutions specifically responsible for carrying out the objectives of the project is another.

This project will have a positive impact on a growing urban migration trend because it tends to equalize the accessibility and the quality of health care in rural and urban areas. Its scope is nationwide, with regional emphasis regarding regions have been kept to a minimum as the existing health system is being used. It has been deemed preferable to incorporate an existing community outreach system, functioning in only two of the five regions, on a demonstration basis as it is expected that its success will lead to replication under other donor sponsorship in other regions.

In general, the project has been designed to be compatible with the sociocultural environment in which it will be implemented. It does not deprive some groups to benefit others, nor create new structures which would fit clumsily with present activities. To the contrary, present entities and their existing personnel are being strengthened.

Contributing to this sociocultural feasibility and to the general social soundness of the project is the fact that benefits and components' activities are interrelated and build upon each other so they are cumulative and synergistic. The same principle operates over time: benefits yield benefits. These phenomena accrue in large part because the project does not reinforce institutionalized dependencies but assists the Togolese in helping themselves.

This analysis has two major parts:

a. Project Beneficiaries

Project beneficiaries are numerous and widespread. In the short run, direct beneficiaries consist of the following groups:

-- the Unit Director and two Unit Coordinators who will receive intensive in-service training;

-- MOH officials receiving planning and budgeting training, totalling about 105;

-- up to two MOH officials receiving U.S. MA degrees;

-- up to one hundred MOH personnel participating in management seminars;

-- the SNES Prefecture Health Education Team members who will receive training in planning and budgeting and in specialized Child Survival areas, numbering 42;

-- 120 Community Agent's and another 15 supervisory staff and regional social affairs directors, trained and supported in varying degrees; and,

-- 1,300 rural-based staff of the Directorate of Public Health and 400 Regional Social Affairs personnel participating in prefecture-level project activities, numbering about 1,700.

These short-run, direct beneficiaries total about 2,636.

In the short-run, indirect beneficiaries include:

-- about 1,250,000 rural Togolese receiving improved Child Survival service delivery from Health Centers;

-- the conservatively estimated 250,000 contacted through outreach network activities, of whom at least one-third are estimated to put into practice some of the Child Survival and community self-help techniques they have learned;

-- students in medical training institutions who have a modern facility, with up-to-date equipment, to learn and practice Child Survival techniques;

-- colleagues of the 105 MOH officials receiving planning and budgeting training who will become familiar with the process by participating in and observing it; and,

-- the total population of about 3,000,000 who receive Child Survival-related messages via mass media pursuant to project-sponsored IEC activities.

In the long-run, indirect beneficiaries include:

-- the total rural Togolese population numbering about 2,175,000 which benefits from better access to improved delivery and quality Child Survival services accruing from regional planning and coordination; and,

-- the 40 percent of the rural population in the three regions not participating in the Community Agents subcomponent which in turn will be contacted by similar activities modeled on this project's activities under the sponsorship of other donors, estimated at 400,000.

b. Spread Effect

This project's spread effect accrues from a combination of factors. The most obvious is the IEC effort that will be undertaken, including mass media, printed materials, and field worker-transmitted messages. Planning, budgeting, and -- especially -- coordination, will maximize diffusion of Child Survival information and services throughout Togo, and will promote dissemination to areas of most urgent need. Because the management skills acquired during this project for application to Child Survival are effective and interchangeable, their application can be expected to spread to all endeavors within the MOH domain. As a consequence, service quality and delivery will improve throughout the health sector. Regarding outreach activities, the Community Agents model has been shown to be replicable and its expansion and duplication will be encouraged by project-sponsored coordination efforts.

6. ENVIRONMENTAL

The institution building, training, Child Survival and family planning activities meet the criteria for Categorical Exclusion in accordance with all or portions of Sections 22 CFR 216.2 (c)(2)(i), (v), (viii), and (xiv), and have been excluded (Annex G) from further review because they will neither directly affect the environment nor have a significant adverse impact on the environment.

IMPLEMENTATION SCHEDULE

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

PERIOD	ACTION	RESPONSIBILITY
PRE-IMPLEMENTATION:		
	PIO/T for US-procured Technical Assis.	Mission
	PIO/T for US PSC for Agents' Assistant.	Mission
	PIO/T for Togolese Teams' Assistant.	Mission
	Nomination of Unit Director and of 2 MOH Unit Coordinators.	GOT
FIRST QUARTER, MONTHS 1-3:		
	Project Agreement Signed (1).	GOT-Mission
	Unit Organized--Unit Director & 2 MOH Unit Coordinators seconded (1).	GOT
	Unit premises procured/equipped (1).	GOT & Mission
	Advisory Board organized, Chairman designated (1).	GOT(MOH)
	RWSSP Accountants & Support Staff engaged for Health Sector Child Survival Project (1).	GOT Contract
	Procurement process of long-term tech.asst. services from an 8A firm initiated.	AID/W
	Agents' Assistant PSC signed (2).	Mission-REDSO/WCA
	Teams' Assistant PSC signed (2).	Mission-REDSO/WCA
	Child Survival Commission organized, & President designated (3).	Unit/Board/Mission/both Assistants
SECOND QUARTER, MONTHS 4-6:		
	RWSSP capital assets transferred (4).	GOT

Teams' and Agents' Assistants begin services (4-39).	Both Assistants
Advisory Board meets twice, to continue meeting at least twice a quarter throughout this project.	Board
Commission meets twice to continue meeting at least twice a quarter throughout the project.	Commission
Agents' first refresher courses in community mobilization, to total about 15 during the project.	Agents' Assistant
Four Child Survival Field Days held to total about 45 during the project.	Agents' Assistant

THIRD QUARTER, MONTHS 7-9:

Long-term tech. assist. contract signed (about 7).	AID/W
ETA Health Planner (9--to stay thru 44).	TA Contractor
ETA IEC Specialist (9--to stay thru 44).	TA Contractor
Teams' training in communications skills for enhanced interpersonal & community relations beings, to total about 15 1-day sessions per Team during the project.	Teams' Assis. & IEC Specialist
Teams' training in coordinated planning & implementation of health activities begins, to total about 15 1-day sessions per Team during the project.	Teams' Assis. & Health Planner

FOURTH QUARTER, MONTHS 10-12:

Ten Year Policy&Strategy Paper drafting begins.	Unit,Senior/Advisor/Planner
Planning/Budget materials & standardized forms preparation.	Unit,Senior Advisor/Planner
Planning/Budget materials & standardized forms field testing begins.	Unit,Senior Advisor/Planner
Format for Collaborative Protocols drafted.	Unit,Senior Advisor/Planner

FIFTH QUARTER, MONTHS 13-15:

Ten Year Child Survival Policy & Strategy Paper promulgated.	MOH/MOP/President

Planning/Budget Training begins with the following Indicative Scenario & suggested locations: Nat'l.-Level Directorate & Division Chiefs, 3 days (early 13): Lome. Nat'l.-level Operational Staff 3 above days plus 2 more days (early 13): Lome. Regional officials, 2 days (mid 13): Lome. Prefect-level personnel, 1st region, 4 days (late 13): regional capital. Prefect-level personnel, 2nd region, 4 days (week 1, 14): regional capital. Prefect-level personnel, 3rd region, 4 days (week 2, 14): regional capital. Prefect-level personel, 4th region, 4 days (week 3, 14): regional capital. Prefect-level personnel, 5th region, 4 days (week 4, 14): regional capital.	Unit,Senior Advisor/Planner IEC Specialist, Collaborative Agencies, Short-term Tech. Asst.
Child Survival Inventory finished.	Unit, PSC, Commission Collaborating Agencies/Short-term Technical Assistance
Participants leave for US Masters trng.	Mission, Unit, MOH
Teams' and Agents' Child Survival trng. pursuant to Collaborative Protocols begins, to continue throughtout the project on an "as available basis".	Unit, MOH entities, other organs. such as CCCD, UNICEF, Donors, PVOs, religious organizations.
SIXTH QUARTER, MONTHS 16-18:	
Directive to initiate Planning/Budget GOT exercise (early 16).	GOT
Reinforcement Assistance to preparers: Up to 2, 5-day trips to each region if needed.	Unit, Long-term tech. asst.
Plan/Budget materials submitted to Unit (end 18).	Nat'l., Reg'l., & Prefecture MOH Personnel
Child Survival 8 Year Trng. Plan finished.	Unit, PSC, Collaborating Agencies, Short-term tech. asst.
SEVENTH QUARTER, MONTHS 19-21:	
Analysis of planning/budget materials, forms submitted.	Unit,Senior Advisor/Planner

GOT negotiations for funds allotment to MOH.	MOH, assisted by Unit Director and Senior Advisor/Planner
Recurrent cost/sustainability study.	Unit, Senior Advisor/Planner Short-term tech. asst.
Mid-term evaluation	Short-term Tech. Asst., REDSO/WCA, Unit, Mission, Long-term tech. asst., PSCs, collaborating Agencies

EIGHTH QUARTER, MONTHS 22-24:

Announcement of funds allotment--to MOH inter-alia.	GOT
Follow-up planning & budgeting recapitulation sessions--1-day ea. nat'l. reg'l. (both in Lome), & 5 Prefectures (in respective reg'l. capitals.	Unit, Long-term tech. asst.

NINTH QUARTER, MONTHS 25-27:

Solicitation of A&E Services for construction of 2 Child Survival Demo. Centers.	Mission
Mid-term audit (25).	Financial Management IQC

TENTH QUARTER, MONTHS 28-30:

Construction completed of 2 Child Survival Demonstration Centers.	Construction firm, A&E firm

PROJECTIONS OF SUBSEQUENT ACTIONS UNDER PLANNING AND COORDINATION COMPONENT

ACTION	ESTIMATED TIME	RESPONSIBILITY
2nd Directive to initiate Plan/ Budget exercise.	month 28, 10th Q	GOT
Plan/Budget materials/forms submitted to Unit.	month 30, 10th Q	Nat'l, Reg'l, Prefecture MOH personnel
Unit analysis, recommendation drafting.	month 31, 11th Q	Unit, Senior Advisor/Planner
GOT funds allocation announcement.	month 33, 11th Q	GOT
Recapitulation session (1 day each Nat'l, Reg'l, 5 for prefectures).	12th Q	Unit, Senior Advisor/Planner
3rd Directive to initiate Plan/ Budget exercise.	month 40, 14th Q	GOT
Plan/Budget materials/forms submitted to Unit.	month 42, 14th Q month 43, 15th Q.	Nat'l, Reg'l, Prefecture MOH personnel
Unit analysis/recommendations drafting.	month 43, 15th Q.	Unit, Senior Advisor/Planner
GOT funds allocation announcement.	month 45, 15th Q.	GOT
Recapitulation session (1 day each Nat'l, Reg'l, 5 for Prefectures).	16th Q	Unit
ETD Senior Advisor/Planner.	end month 44	Long-term tech. asst. contractor
ETD IEC Specialist.	end month 44	Long-term tech. asst. contractor

FINAL EVALUATION AND AUDIT SCHEDULE

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

ANNEX K

PERSONS CONTACTED

Sharon Capeling
Deputy Director of CUSO

Peter Delahaye
Representative UNICEF

Nancy Michelsen
Representative CRS Togo

Ethlyn Lloyd
Program Director CRS

Mrs Hamel
Director
Volunteers of Progress (French)

Emmanuel Mbi
Resident Representative
World Bank

Errol Williams
Health Education Trainer
WHO Regional Training Center

Ambassador Korn
US Ambassador to Togo

Marc Baas
DCM American Embassy

Myron Golden
A.I.D. Representative

Barbara D. Howard
A.I.D. Program Officer

Robert Nicolas
Peace Corps Director

Mrs Eva-Maria Wiese
UNFPA Representative

Dr. Eben Moussi
Representative WHO

Prof. Aissah Agbetra
Minister of Public Health,
Social Affairs and
Women's Condition

Bini Kilim
Director Of Cabinet
Ministry of Health

Mrs Aminata Traore
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Icha Tchao
Attaché de Cabinet
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Director General of Public Health
Ministry of Public Health

Dr. H.A. Gayibor
Chief of National Malaria Service

Mrs A. Aithnard
Director General of
Women's Condition

Dr. Tchasseu Karua
Director of Epidemiology
National Coordinator CCCD Project

Dr. Komla Mensah Siamevi
Chief of National Health
Education Service

Dr. Barandao Bakele
Assistant Dir. Gen. Public Health

Mrs Takouda Nignigaba
Assistant Director General
Women's Condition

Mrs. Laban Ayawovo
Director of Division
Family and Child Protection
Social Affairs.

Budema B. Fisima
Chief Division Wom,en's Education
Women's Condition

Joe Naimoli
Peace Corps Volunteer
National Health Education Service

Tchatombe Ouro-Bawinay
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Alan Malina
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Atakpame

Robert Deutsch
Technical Advisor RWSS
Dapaong

Louis O'Brien
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Togo Rural Water Supply and
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Mr. Mensah
Director
Togolese Association for
Family Welfare (ATBEF)

Mr. Agbo
CONGAT

Virginia Yee
International Nutrition Unit
LTS Corporation

Kate Kokou
Director General
Social Affairs

Mr. Nenonene
Chief - National Sanitation Service

Prof. A. D'Almeida
Studies Coordinator
WHO Regional Trg Center

Prof. Kossi Assimadi
Dept. of Pediatrics, CHU

Agba-Tadjali Akoleum
Director Division of Community Dev.
Social Affairs

Mr. Kolani T. Beithien
Community Development

Dr. K. Houngues
Ministry of Plan and Mines

Mr.Edorh
Regional Director of Sanitation
Plateaux Region

Mr. Kassime
Regional Supervisor RWSS
Savanes Region

Atakpame:
Mr. Sokode
Regional Director
Social Affairs

Mr. Madjome
Regional Supervisor of RWSS
and Social Affairs

Mr. Adodo
Regional Supervisor for
Literacy/Social Affairs

Mrs Akogo
Social Promotion Agent
Social Affairs

Mr. Hessou
Social Promotion Agent
Social Affairs

Mr. Ketoglo
Former Regional Director
Social Affairs

Notse:

Mr. Deglo
Medical Assistant
Notse Hospital

Mr. Kossi
Chief Sector
Social Affairs

Mr. Gblokpor
Social Promotion Agent
Social Affairs

Mr. Tata-Deki
Sanitation Assistant

Mr. Kpeliti
Social Promotion Agent
Social Affairs

Mr. Yata
Prefect of Notse Prefecture

ANNEX L

SCOPE-OF-WORK

Prefecture Health Education Teams

Supervision : Chief Medical Officer of the Prefecture

Technical Support: National Service for Health Education (SNES)

1. Area of Responsibility: Community Mobilization for Child Survival (50 percent) - In collaboration with village leadership and Village Development Committees, the Health Education Coordinator, the Assistant Coordinator and a Peace Corps Volunteer will:

A. Plan and implement surveys of mothers' practices upon the onset of childhood fever and diarrhea, and in preventing infectious diseases.

B. Plan and implement a series of "focus group" interviews with mothers to discover the reasons for the practices inventoried in "A" above (i.e., knowledge, attitudes, beliefs, prior experiences, etc.).

C. Utilize the data collected in "A" and "B" above to design, implement and evaluate a minimum of two and maximum of three health education "campaigns" based upon the following interventions: vaccination, oral rehydration therapy and presemptive treatment of fever with Chloroquine.

Camapigns will be conducted in two "focus" villages over a two-year period with diffusion to surrounding villages. Each "focus" village will be located within a three kilomter radius of a "fixed site" service delivery post. A "fixed site" is a rural health post with a regular supply of cold storage vaccines, oral rehydration salts and chloroquine.

2. Area of Responsibility: In-service Training in Patient Health Education for Child Survival in frontline health personnel (40 percent):

In collaboration with the Chief Medical Officer of the prefecture and staff of the National Service for Health Education, teams will:

A. Co-facilitate regional workshops of the national in-service training program in health education for all categories of health service delivery personnel.

B. Organize, implement and evaluate prefectural workshops in patient health education for child survival for all categories of frontline health personnel.

C. Visit a sample of personnel trained during these regional and prefectural workshops on a regular basis at their work sites to assure the application of training in the field with the target population.

D. Pretest all educational materials and visual aids developed at the National Service for Health Education.

E. Participate in any and all evaluations of the in-service training program at regional and prefecture levels.

3. Area of Responsibility: Team Projects in Primary Health Care (10 percent)

All Prefecture Health Education Teams are encouraged to develop new or strengthen existing health education components within on-going primary health care programs in the fields that address areas of particular concern to the prefecture. Examples of such areas include: growth monitoring, breastfeeding, birth spacing, guinea worm control, village pharmacies, school health, etc.

CHART A.2

DG/PH ORGANIZATION

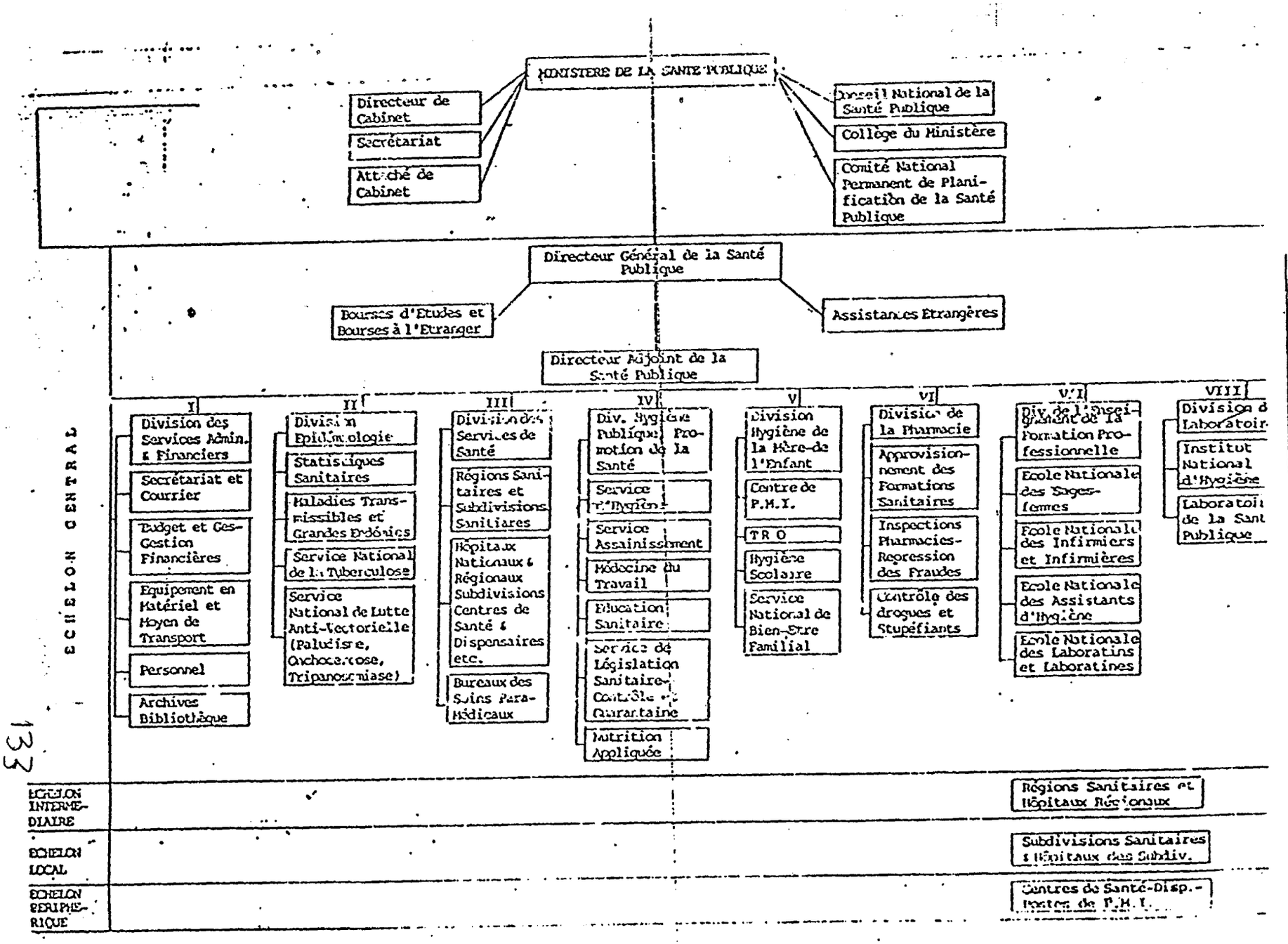
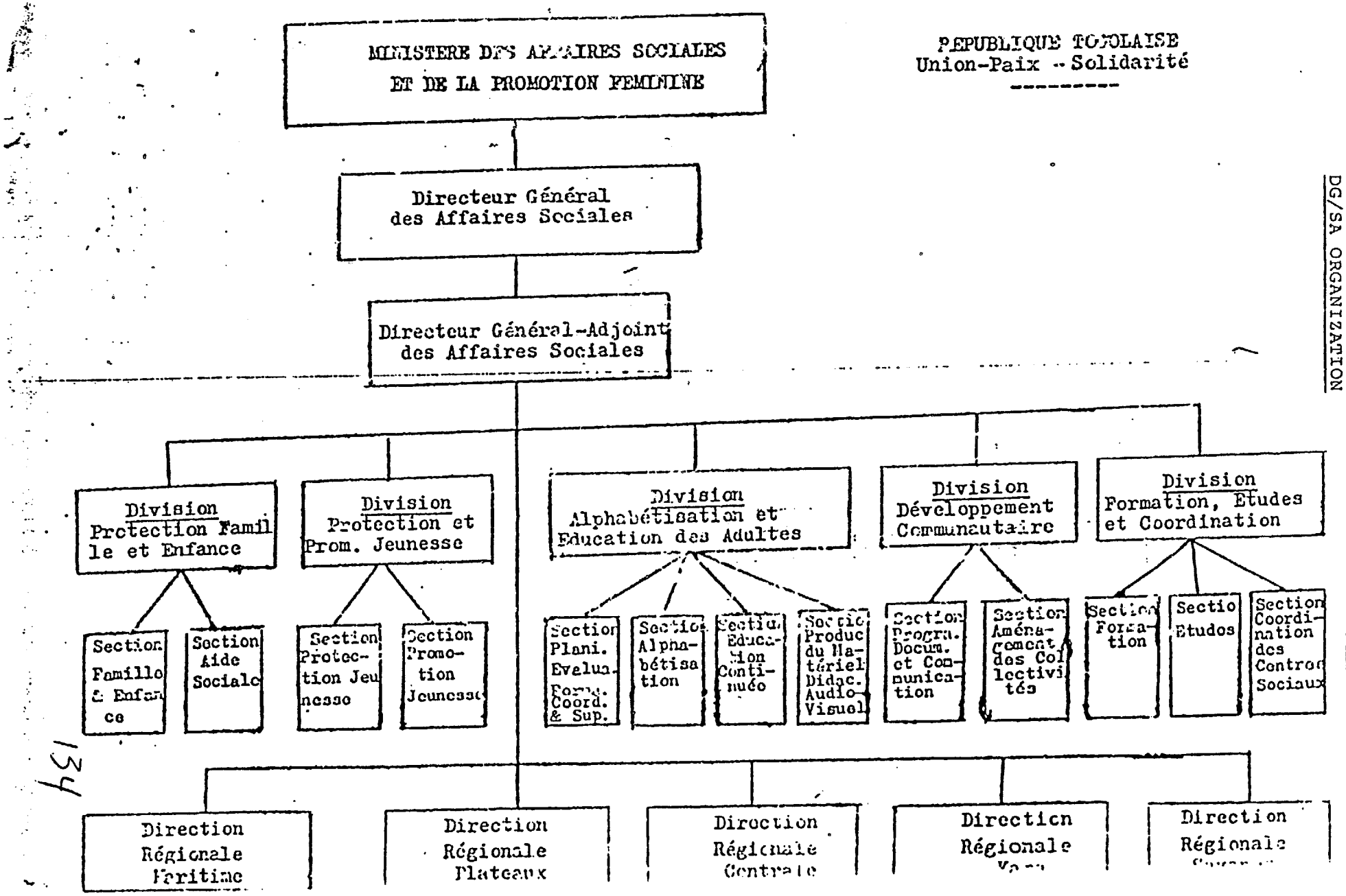


CHART A.2

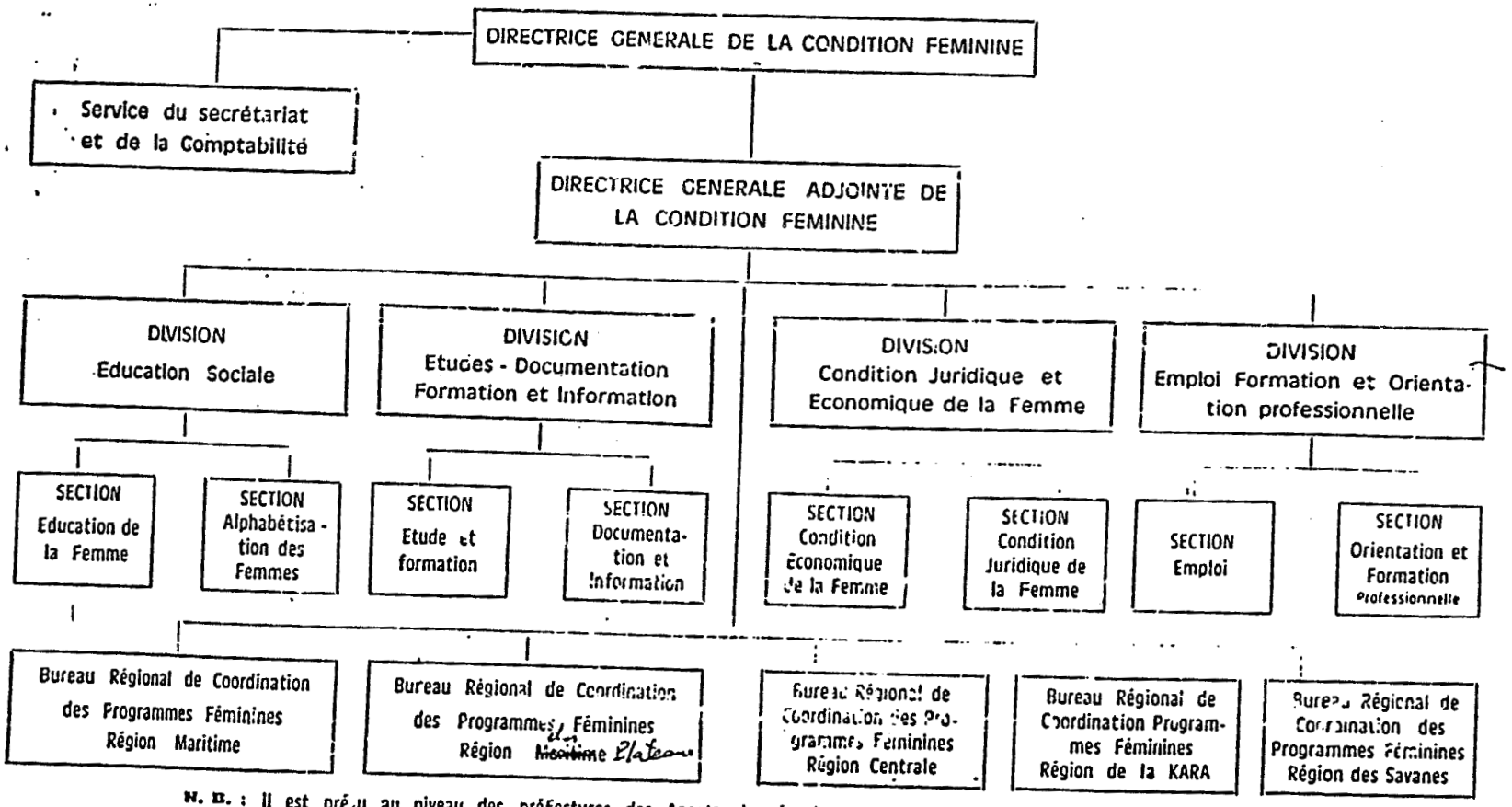
DG/SA ORGANIZATION

REPUBLIQUE TOGOLAISE
Union-Paix -- Solidarité



ORGANIGRAMME

DE LA DIRECTION GENERALE DE LA CONDITION FEMININE



N. B. : Il est prévu au niveau des préfectures des Agents chargés des programmes Féminins, et au niveau des villages des Animatrices de programmes Féminins

DG/WC ORGANIZATION

CHART A.3

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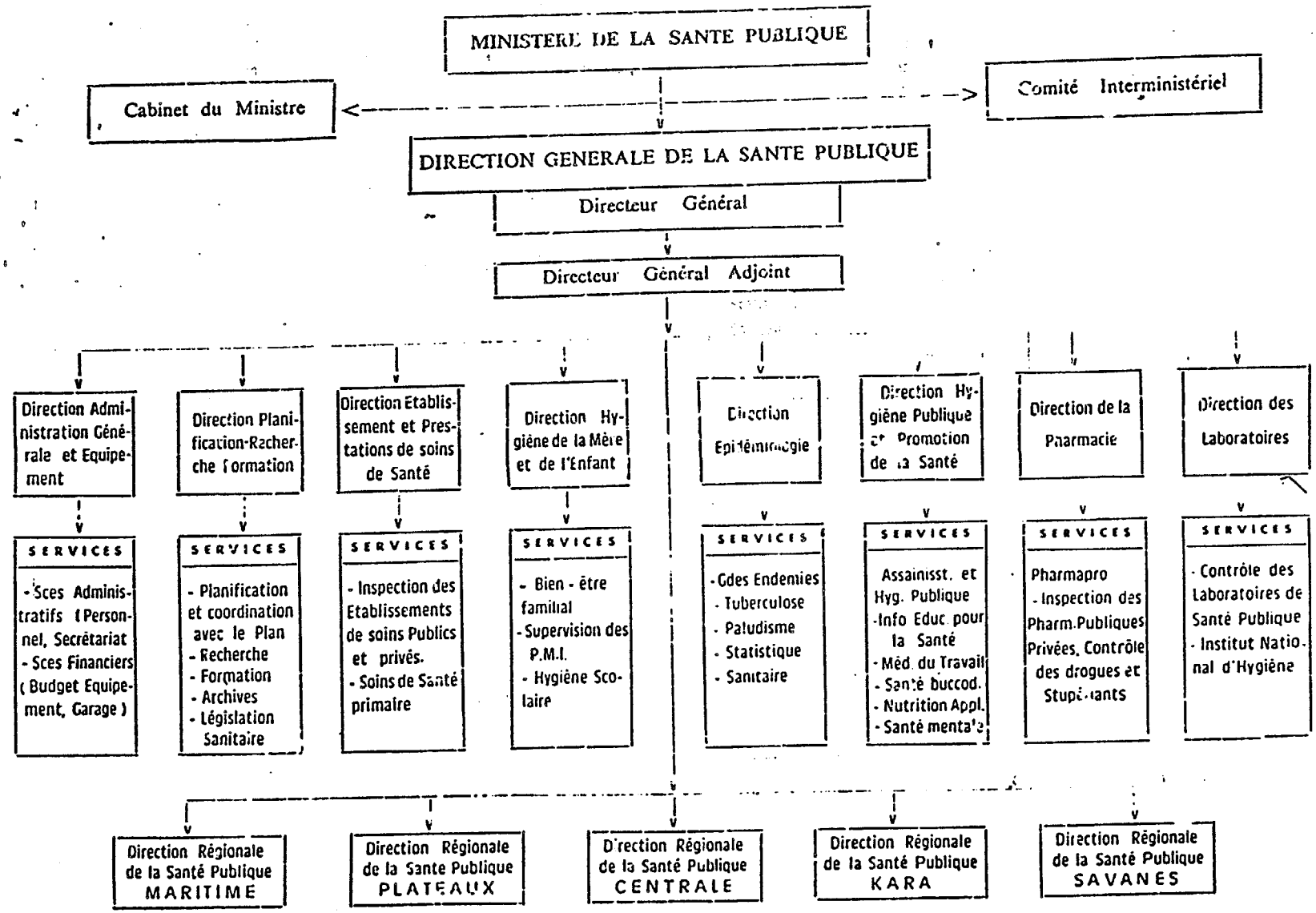

PROPOSED MOH ORGANIZATION

CHART B

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CHART C

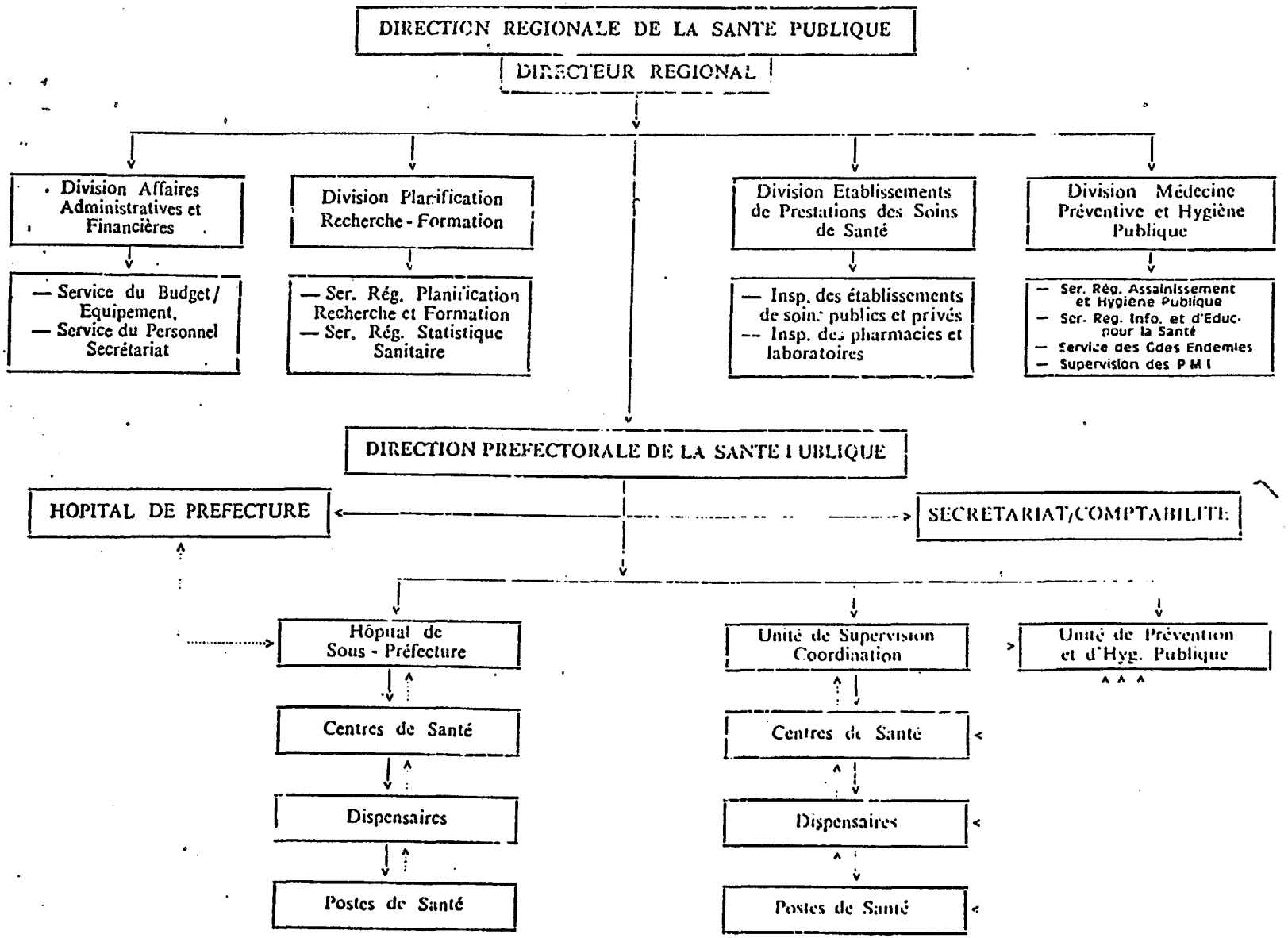
DIRECTION REGIONALE DE LA SANTE PUBLIQUE
DIRECTEUR REGIONAL
Division Affaires Administratives et Financières
— Service du Budget/ Equipement.
— Service du Personnel Secrétariat
Division Planification Recherche - Formation
— Ser. Rég. Planification Recherche et Formation
— Ser. Rég. Statistique Sanitaire
Division Etablissements de Prestations des Soins de Santé
— Insp. des établissements de soins publics et privés
— Insp. des pharmacies et laboratoires
Division Médecine Préventive et Hygiène Publique
— Ser. Rég. Assainissement et Hygiène Publique
— Ser. Reg. Info. et d'Educ. pour la Santé
— Service des Cdes Endemies
— Supervision des P M I
DIRECTION PREFECTORALE DE LA SANTE PUBLIQUE
HOPITAL DE PREFECTURE
SECRETARIAT/COMPTABILITE
Hôpital de Sous - Préfecture
Centres de Santé
Dispensaires
Postes de Santé
Unité de Supervision Coordination
Centres de Santé
Dispensaires
Postes de Santé
Unité de Prévention et d'Hyg. Publique

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TABLE C

OTHER DONOR CHILD SURVIVAL ACTIVITIES

PROGRAM DESCRIPTION	DONOR	DURATION	TOTAL	1984	1985	FUTURE	DONOR /LOAN	DETAILS
CHU, Lome	BAD/NTF		6,500,000		6,030,000		L	
Surgery for CHU	Germany				667,000		D	
Project Measure /follow up	Germany			715,000			D	
CHU Sub Total			6,500,000	715,000	6,697,000	0		
Vaccination	OMS		249,000	89,000	45,000	160,000	D	
Vaccination	PNUD/USAID	1986-1987	170,000			170,000	D	736,000 dosis of vaccine
EPI	UNICEF	1985-1988	350,000		73,000	277,000	D	Vaccines, mat. & equip.
Endemic Diseases	UNICEF			57,000			D	Vaccines
Immunization Sub Total			769,000	146,000	118,000	607,000		
Anti-diarrheal (ORT)	UNICEF	1985-1988	424,000		98,000	326,000	D	ORS pacquets, growth charts,etc
Mother & Child Health	OMS		90,000	40,000	20,000	50,000	D	
Mother & Child (PMI)	UNICEF	1985-1988	238,000		43,000	195,000	D	Equipment for PMI centers
Infant Mortality	UNICEF	1985-1988	106,000		20,000	86,000	D	Studies on rural infant mortality
School Pharmacies	UNICEF	1985-1988	81,000		19,000	62,000	D	
School (Midwives & Med. Asst.)	UNICEF		5,000				D	Medical equipment
PMI Sub Total			515,000	45,000	102,000	393,000		
Health Info. & Ed.	OMS		143,000	100,000	50,000	43,000	D	
Health Education	Peace Corps	1980-		112,000	57,000		D	11 trainers, equip. in '84; 5 TTs in '85
Nat. School Med. Asst.	RFA Vol.	1975-1984		26,000			D	2 therapists (training)
Health Education	UNICEF			2,000			D	Audio-visual Equipment
Health Education (SNES)	UNICEF	1985-1988	93,000		23,000	70,000	D	audio-visual mat., vehicle
Health Education Sub Total			236,000	240,000	130,000	113,000		

PROGRAM DESCRIPTION	DONOR	DURATION	TOTAL	1984	1985	FUTURE	DONOR /LOAN	DETAILS
Micro realizations	FAC			25,000	16,000		D	Health Centers/Dispensaries
Aid for the Gen. Dir. Pub. Health	FAC			23,900	22,000		D	direct interventions
Health "	Japan	June 1984		1,050			D	12 ambulances and health mat.
Nat. Health Develop.	OMS		533,000	250,000	125,000	283,000	D	
Organize Health System	OMS		260,000	100,000	50,000	120,000	D	
Research Promotion	OMS		35,000	20,000	10,000	15,000	D	
Health Sit. Analysis	OMS		60,000	30,000	15,000	30,000	D	
Health	PAM	1982-1986	8,960,000	43,000	96,000		D	Food distr. for disp. & latrine cons.
Public Health Garage	RFA Vol.	1980-1985		13,000			D	1 mecanic
Regional Hospitals	RFA Vol.	1979-1984		13,000			D	1 therapist
Public Health Garage	UNICEF			23,000			D	Materials
Health Infrastructure Sub Total			9,848,000	541,050	334,000	448,000		
Medical Mission.	China						D	Doctors (Kara & Lome)
Technical Assistance	FAC			523,000	450,000		D	16 PH techs./Drs in 1984; 13 in '85
Health (Savannah, Kara, Sokode)	French Vol.			55,000	66,000		D	5 volunteers in 1984; 6 in 1985
Health Personnel	OMS		400,000	200,000	100,000	180,000	D	
Medical Sub Total			400,000	778,000	616,000	180,000		
Malaria	OMS		98,000	40,000	20,000	58,000	D	
Malaria	UNICEF	1985-1988	113,000		17,000	96,000	D	Chloquine and training
Malaria Sub Total			211,000	40,000	37,000	154,000		
Nutrition (schools)	Cathwell	1984		39,000			D	Admin., tech. & train. Supp.
Infant Nutrition	Cathwell/AID	1982		170,000		371,000	D	
Nutrition in Biankuri	Cathwell/CAN	1984		5,000			D	Training Mat.
Nutrition	OMS		30,000	20,000	10,000	10,000	D	
Nutrition	UNICEF			31,000			D	Avicole material
Nutrition	UNICEF	1985-1988	229,000		82,000	147,000	D	equipment
Nutrition Sub Total			259,000	265,000	[illegible]	[illegible]		

PROGRAM DESCRIPTION	DONOR	DURATION	TOTAL	1984	1985	FUTURE	DONOR /LOAN	DETAILS
Water for Lome	BIRD/IDA	1984	12,000,000	120,000	400,000		L	
Potable Water	BOAD	1983	3,448,000					L
Potable Water	DANIDA	1985-	9,437,000		458,000	8,979,000	D	Potable water for major cities
Research	DANIDA	1985	42,000		42,000		D	Study for water project
City Water (Dapaong)	FAC	1984-	582,000	70,000	21,000	512,000	D	Drilling, studies, equipment
Forage (health center, Amou Oblo)	FAC				16,000		D	
Water Forage	Germany	1984	2,500,000	1,250,000	1,200,000		D	Financial help
Water and Sewage	OMS		180,000	40,000	20,000	131,000	D	
Nat. Activ. Potable water decade*	PNUD/OMS	1983-1986	963,000	92,000		175,000	D	1 coordinator
Socio-Sanitary project	Peace Corps	1981-		102,000	91,000		D	10 animation vols. in '84; 8 in '85
Water and Sanitation	USAID	1980-1987	11,739,000	2,292,000	1,608,000		D	Drilling, education
Assanisement	PC Partner.			5,000	1,000		D	Cistern & disp. cons., pumps
Latrines	PC Partner.				400		D	
Water & Sanitation Sub Total			40,891,000	3,971,000	3,937,400	9,797,000		
Intestinal Parasitosis	CERDI	1985-1986	17,000		6,000	11,000	D	
Leprosy	RFA Vol.	1967-		10,000	x		D	8 nurses in '84, 5 volunteers in '85
Pian	UNICEF			8,000			D	Drugs
Dracunculosis	UNICEF	1985-1988	87,000		22,000	65,000	D	Local prod. water filters, training
Guinee Worm (Water & Hygiene)	CERDI	1985-1989	58,000			58,000	D	
Leprosy	UNICEF			10,000			D	Drugs
Tuberculosis	UNICEF			18,000			D	Material/equipment
CCCD	USAID	1983-1987	1,140,000					
Other Sub Total			1,302,000	46,000	28,000	134,000		
TOTAL EXPENDITURE			61,355,000	6,787,050	12,119,400	12,680,000		

* The total project figure is regional, however the 1984 and the future figures are Togo specific.

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