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HEALTH SECTOR ANALYSIS

TOGO

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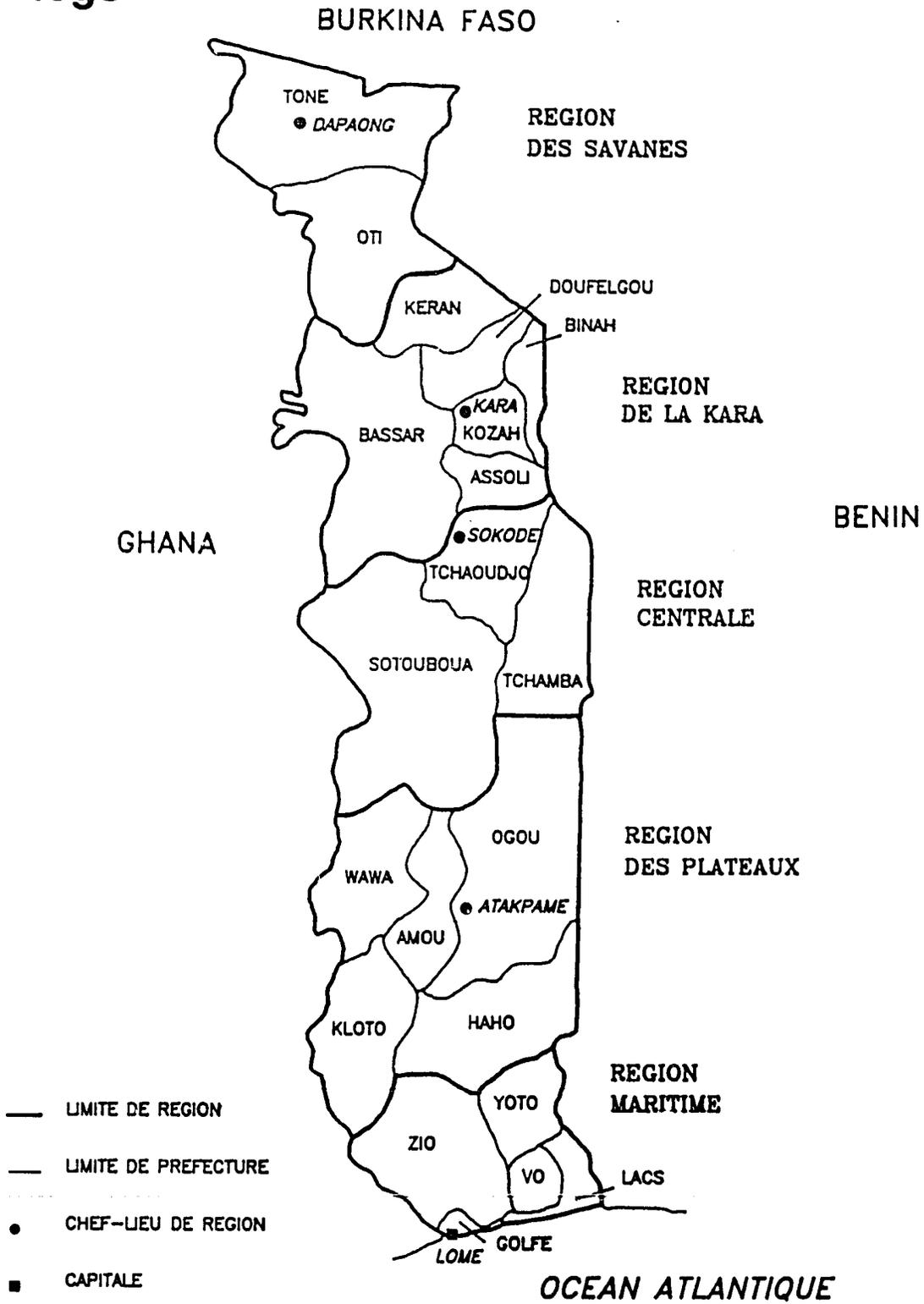
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ACRONYMS

ATBEF	Association Togolaise pour le Bien-Etre Familiale - Togolese Family Planning Association
AVT	Action Vaccination Togo -- Immunization Action Program of Togo
CCCD	Combatting Childhood Communicable Diseases Project
CDD	Controlling Diarrheal Diseases
CHR	Centres Hospitaliers Régionaux -- Regional Hospitals
CHU	Centres Hospitaliers Universitaires -- University Teaching Hospitals
CNSS	Caisse National de Sécurité Sociale -- National Social Security Agency
CPC	Contrôle de Promotion de la Croissance -- Growth Monitoring
CNI	Centre de Nutrition Infantile -- Child Nutrition Center
CUSO	Canadian University Service Overseas
CVD	Comité Villegois de Développement -- Village Development Committee
DHS	Demographic Health Survey
DME	Division de la Mère et de l'Enfant -- Division of Mother and Child Health
DRDR	Direction Général du Développement Rural -- Rural Development Ministry
EPI	Expanded Program of Immunization
FAC	Fonds d'Aide et de Coopération -- French Foreign Assistance Agency
FED	Fonds Européen de Développement -- EEC Foreign Assistance Agency
FHI II	Family Health Initiative II
GOT	Government of Togo
GTZ	German Development Assistance
HIS	Health Information System -- epidemiological data
H/MIS	Health Management Information System
HSSCS	Health Sector Support for Child Survival Project
IEC	Information, Education and Communication
KAP	Knowledge, Attitudes and Practices Study
LMD	Lutte Contre les Maladies Diarrhéique -- Controlling Diarrheal Diseases
MASCF	Ministère des Affaires Sociales et de la Condition Feminine -- Ministry of Social Affairs and Women's Condition
MCH	Maternal and Child Health
MOPH	Ministry of Public Health
MSP	Ministère de la Santé Public -- Ministry of Public Health
NGO	Non-governmental Organization
OCCGE	Organisation de Coordination et de Coopération pour la Lutte Contre les Grandes Endemies -- Organization of Coordination and Cooperation for Control of Endemic Diseases.
ORS	Oral Rehydration Salts (packets)
ORT	Oral Rehydration Therapy
OMS	Organisation Mondiale de la Santé -- World Health Organization

PEV Programme Elargi de Vaccination -- Expanded Program of Immunization
PHC Primary Health Care
PMI Programme Maternal et Infantile -- Maternal and Child Health Program
PNBEF Programme National de Bien-Etre Familial -- National Family Planning Program
REDSO/WCA Regional Economic Development Services Office/West and Central Africa (USAID)
RPT Rassemblement du Peuple Togolais -- Togolese Peoples' Party
SMI Santé Maternelle et Infantile
SNES Service National de l'Education pour la Santé -- National Health Education Service
SSS Sugar and Salt Solution
UNFPA United Nations Fund for Population Activities
UNICEF United Nations Children's Fund
UPC Unité de Planification et de Coordination -- Planning and Coordination Unit of Ministry of Public Health
WHO World Health Organization

Togo



EXECUTIVE SUMMARY

HEALTH AND POPULATION SITUATION

Low health status and high population growth remain major problems in Togo. Despite 12 years of commitment to primary health care and recent focused efforts in Child Survival, infant mortality is still estimated at the high rate of between 80 and 130 per 1000 live births. Malaria, infectious diseases and diarrhea continue to be the major killers. Low nutrition levels contribute to morbidity and mortality. Maternal mortality is high. Population growth has remained high and relatively constant at 2.9% and a birth rate of 45 per thousand live births.

The health system has expanded services to facilities throughout the national territory and, with WHO, UNICEF and USAID support has recently made major effective efforts to improve immunization coverage and to reorient the malaria program's treatment policy.

Initial steps are being taken in family planning in both the private and public sectors, with UNFPA and USAID funding and technical assistance.

Recent initiatives have been taken in growth monitoring, control of diarrheal diseases and maternal and child health. New concerns with AIDS and with dracunculosis (guinea worm) have been raised and are receiving donor support. New project activity is promoting community participation and health education efforts in a variety of programs.

Improvements in recording and reporting epidemiological data have occurred with the assistance of USAID's CCCD program, although reliability of statistical data and management information are still in need of considerable improvement.

CONSTRAINTS

These efforts are constrained by two central problems:

- 1) the administrative fragmentation and over-centralization of the Ministry of Public Health -- the dominant health institution in the country.

- 2) declining levels of national funding for the health sector

The Ministry of Public Health (MOPH) provides most of the health services and nearly all preventive programs in the country --

although there is a significant but undetermined private sector in urban areas, mainly in the capital city. The Ministry is currently organized in ways that inhibit efficient and effective implementation of its stated health policies and objectives which emphasize a commitment to Child Survival objectives and to family planning. While budgetary data on programs are difficult to obtain, hospital centered programs are likely to be receiving much greater emphasis than preventive programs.

The Ministry of Public Health is a highly centralized institution, with both major and minor decisions being made in Lome, often by the Minister himself. Almost all programmatic, personnel and budgetary decisions are made at the central level. The sub-districts at the prefectorial level are managed by the Médecin Chef, who has very little authority or discretionary power over programs, personnel or budgets. At the lowest levels, health officials and health providers are subject to changing demands of different vertical programs, inadequate and poorly distributed stocks of medicines and other supplies necessary for basic activities. Even at the central level, decisions are often deferred or ignored because of the press of demands on a few key decision-makers.

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

Most donor activity has reinforced this fragmentation by providing separate budgets and technical assistance for vertical programs, with little incentive or support for integrating mechanisms.

Several programs that involve related ministries and non-governmental organizations (NGOs) -- such as 1) health education efforts involving the Ministry of Public Health, the Ministry of Social Affairs and Women's Condition, the Ministry of National Education, and Catholic Relief Services, or 2) the family planning activities of the Ministry of Public Health and the Togolese Family Planning Association (ATBEF) -- are also not designed to promote coordination. Often they end up as separate and competing activities.

The second major problem is the financing of the health sector. Although the proportion of the national budget that goes to the health sector has fluctuated fairly narrowly between 4 and 5%, national per capita expenditures for health have been declining

consistently since 1978 (in real terms, from 500 FCFA in 1978 to 284 FCFA in 1987). This decline has been accompanied by an overall decline in Ministry personnel and by a gradual shift in budgetary allocation toward salaries (from 69.1% in 1978 to 80.2% in 1987, although the trend began reversing slightly in recent years).

This decline in national expenditure on health has been combined with a major contribution in donor assistance to the sector. Since these funds are targeted to priority Child Survival and family planning activities, this dependence on foreign funding is of major concern. It is not clear that even current activities in these vital areas (which are far from adequate) can be sustained without continued donor support.

NEW INITIATIVES AND OPPORTUNITIES

Fortunately, these constraints are well recognized by both the Government of Togo and by the donors and recent initiatives have begun to address these problems.

As part of a process of designing a new Health and Population Sector Loan from the World Bank, the Ministry of Public Health has developed a major reorganization plan. This plan focuses on rationalizing the central offices into a more integrated structure and decentralizing decision making for program, personnel and budgets to the regional, prefectural, and facility levels. It also promotes cost-recovery and greater involvement of the private sector.

A second approach is UNICEF's sponsored Bamako Initiative, which has received some initial pilot support from the German government in one region. This approach emphasizes the development of village pharmacies to provide essential drugs at near actual cost to beneficiaries. This effort at cost-recovery may provide affordable medicines on a sustainable basis.

USAID PROGRAMS

USAID has provided significant support for Child Survival and Family Planning activities in Togo. The current USAID portfolio includes four major projects:

- 1) Health Sector Support for Child Survival (HSSCS) -- a project designed to strengthen planning, budgeting and management; health education, and community outreach and organization.

- 2) Combatting Communicable Childhood Diseases (CCCD) -- part of a regional initiative, this project supports EPI, malaria, ORT and health information activities with training, equipment and technical assistance.
- 3) Family Health Initiatives Project II (FHI-II) -- providing support for the public programs of the Ministry of Public Health and the private activities of the Togolese Association of Family Planning (ATBEF)
- 4) PL480 Title II Program -- provides food commodities for supplementary feeding and health and nutrition education programs, managed through Catholic Relief Services, the Ministry of Social Affairs and Women's Condition, and the Ministry of National Education

Each of these projects has contributed to significant improvements in health and population areas. The HSSCS project has had difficulties initiating planning activities, but has been effective in developing a cascade training program for health education in coordination with Peace Corps, the National Health Education Service and the Ministry of Social Affairs and Women's Condition. CCCD, along with significant support from UNICEF, has been effective in improving immunization coverage and in developing and implementing an appropriate strategy for addressing the growing malaria problem. It has also contributed to significant improvements in the health information system. Family Health Initiatives Project II has provided training and technical assistance as well as contraceptives for both public and private programs. The Title II program has improved health and nutrition education in the Ministry of Social Affairs and Women's Condition's Centers for Child Nutrition (CNI) and provided school lunches and gardens in a selected number of primary schools.

A major problem that has arisen in implementation of these projects is the lack of coordination and integration of their activities - adding to the fragmentation within the Ministry of Public Health. All four projects are also a growing management burden on the Office of the USAID Representative, especially with the growth in regional USAID activities located in Lome.

Three of these projects are due to close at the end of 1991. This health sector analysis was designed, in part, to propose areas for USAID future activity during the following five years.

RECOMMENDATIONS

USAID should build on the advances and strengths of the current projects, reorient them and reorganize project design so as to take advantage of the new government and donor efforts to address Ministry reorganization and improve financing and sustainability.

We propose that USAID consolidate the three projects into one single project managed by an outside consulting firm. This approach will encourage greater integration of the sub-component activity and reduce the management burden on the Office of the USAID Representative.

We propose a single project with three sub-components:

- 1) Management and Planning Information System Support -- This sub-component would involve a redesign of the HSSCS activity to focus on the development and utilization of a unified and decentralized management information system that can form the basis for integration of activities, management, planning and supervision, especially at the prefectoral service delivery level. This subcomponent would also include development of integrated financial systems and health financing studies. This sub-component should also provide support to the 1991 Census and a second Demographic and Health Survey (DHS).
- 2) Child Survival Interventions and Health Education-- This sub-component would reorient the CCCD program to phase out of, and encourage the sustainability of, the already effective immunization and malaria programs, while giving greater emphasis to control of diarrheal diseases, nutrition and maternal and child health, currently the weaker programs in Child Survival. This sub-component would also contribute to the management and planning information system and integrate its activities, along with those of Family planning into the broader Maternal and Family Health program. Building on the effective health education program of HSSCS, Peace Corps and the National Health Education Service (SNES), this sub-component would continue to support health education activities with SNES and encourage integration of health education activities of all interventions.
- 3) Family Planning -- The orientation of this sub-component would be to expand support for the public sector program and strengthen its integration into management information system and the activities of the maternal and child health program. USAID support for ATBEF would shift its emphasis toward social marketing activities. Greater efforts to enlist greater centrally funded buy-in technical assistance from SEATS, INTRAH, and SOMARC in both activities, would be encouraged.

At the present time, sufficient activity and donor support is being given to activities for AIDS, dracunculosis, and acute respiratory infection (ARI). Given limited absorptive capacity in the Ministry of Public Health and the comparative advantage of continuing to build on previous program strengths, no major sub-component

activity should be designed in these areas. The future of the PL480 Title II project and possible integration within the overall USAID health and family planning program should be determined after a full evaluation, scheduled in late 1990, is completed.

A single project, with its central emphasis on integration and decentralization through development of a management and planning information system, would provide focused support for obtaining broader sectoral objectives of the Ministry reorganization envisioned as part of the Health and Population Sector Loan from the World Bank. The health financing activities of the management and planning information system sub-component could support the decentralization and cost recovery objectives of both the World Bank Loan and the Bamako Initiative. The Child Survival and Family Planning components would continue the complementary efforts of USAID, UNICEF, UNFPA, WHO and other major donors.

I. BACKGROUND

A. Objectives of this Health Sector Assessment

Three USAID health and population projects in Togo are due to end in 1991. This health sector assessment is designed to assist USAID in its planning process for the development of new health and population initiatives to cover the following five years. This report presents a brief analysis of the current health sector in Togo and a review of future plans of the government and other donors. On the basis of this analysis, we propose a general approach as a guide for the following phases of project design.

This analysis is based on a four week review (May 8 - June 1, 1990) by a team of two international consultants (experts in project design, health planning, financing, administration and epidemiology), a local health economist, a regional family planning medical advisor from SEATS, representatives of the Ministry of Public Health and the Ministry of Plan. The team also had support from USAID officials from USAID/Lome and USAID/REDSO.

B. Geographic, Demographic, Political and Socio-economic Context

The Republic of Togo occupies a narrow slice of land on the Gulf of Benin between Ghana and Benin which stretches 600 km north to a border with Burkina Faso. With an estimated population of 3.2 million on 56,600 km², Togo's population continues to grow at the high rate of 2.9% per year [Ministère du Plan et des Mines. *Resumés des Analyses du Recensement 1981; Cadre Micro-Economique 1990*].

The geography changes from the humid Maritime Region in the south to the arid Sahel in the northern Kara and Savannes Regions. In between are the productive highland areas of the Plateau and Central Regions where the major export crops of coffee, cacao, and cotton are grown.

Although the population is predominantly rural (74.8% in 1981) the urban areas are growing at twice the rate of rural areas (4.4% vs. 2.4%). The 1981 census found that most of the population (38.3%) resided in the Maritime Region, with 685,339 people in the capital city of Lomé. Other urban areas are Sokodé, Kpalimé, Atakpamé, and Kara.

Ethnic groupings include the Adja-Ewé (44.0%) and Kabye-Tem (26.7%). Around 59% are animist, 28% christian and 12% muslim.

The central road system runs north through the center of the country and is a major transport route for shipments to the land

locked countries to the north. This central road system is in good condition, facilitating health logistics among the major population centers. Road transport, branching off this system east or west, however, is less well developed and many communities remain isolated with limited access to health facilities.

The economy is based on agriculture with most producers engaged in subsistence farming (manioc, yams, corn, and millet). Available estimates suggest that sufficient food is produced to satisfy national food needs during most years. Coffee, cacao, cotton and phosphates are the major export products and have been suffering from low commodity prices throughout the 1980s. After growing consistently from 1965 to 1972 at an average rate of 7.2%, the economy stagnated at an average of 1.7% growth in the 1970s. With the fall in commodity prices in the early 1980s, the economy experienced a major decline from 1981 to 1983 which forced a series of structural adjustment programs. In the last 5 years the economy has shown modest real growth of around 3%, barely keeping up with population growth. [Economist Country Review 1990]

Togo is now considered by the World Bank to be one of the low income countries of Africa, with a per capita income of only US\$ 300. [World Bank 1988]

Since 1983 the government has agreed to three sequential structural adjustment programs with the IMF which have restricted national budgets and credit and have forced modest liberalization of the economy. These adjustments have had a direct impact on the national health system -- leading to budget constraints and reductions in personnel.

Government revenues amounted to only US\$ 334 million in 1989, of which only 5.1% was devoted to health. Togo is highly dependent on foreign assistance, the official aid flows to Togo were estimated by OECD to be US\$ 129.5 million in 1987. USAID is a minor participant; it provided almost US\$ 8 million in 1989. [Economist 1990]

The national administrative system is based on the French administrative model which divides the country into 21 prefectures and 9 sub-prefectures, each with a Prefect who represents the central government. The Prefect heads a Development Committee composed of local officials of each of the active line ministries, including Public Health, National Education, Social Affairs and Women's Condition, and Rural Development. At the Prefect level, the highest Ministry of Public Health official is the Médecin Chef of the Sub-Division (the Ministry's equivalent of the prefecture). The Ministries are highly centralized in the capital with extremely limited budgetary and administrative authority granted to the prefect level.

Five regions (Maritime, Plateau, Central, Kara, Savannes) have been established with representatives from the Ministries of Plan, Social Affairs and Women's Condition, and Rural Development. These regions are headed by the prefect of the capital city in each region (Lomé, Atakpamé, Sokodé, Kara, and Dapaong). Currently, the Ministry of Public Health does not have a regional representative, although the Medecin Chief of the capital prefecture often attends regional meetings.

Since 1969 the country has had a single party of national unity, the Rassemblement du Peuple Togolais (RPT), headed by General Gnassingbe Eyadema. Elected by overwhelming majorities in 1979 and 1986, General Eyadema has presided over a monolithic system that has assured relative stability, punctuated by a number of unsuccessful plots, assassination and coup attempts over the years.

C. Health Policies and Strategies

National health policies have focused on the development of a public health system which has steadily expanded coverage since independence. This public system dominates the health sector. However, there are four private religious-based hospitals and an undetermined number of private individual practitioners -- both traditional and Western.

The broad health strategies have followed continent-wide WHO and UNICEF initiatives. The general strategy since the Alma Ata Conference of 1978 has been on the expansion of coverage and on primary health care. Nevertheless, considerable efforts have gone into the construction and operation of large hospital facilities, especially the University Teaching Hospitals in Lomé, which alone consume over one-third of the national health budget.

Current emphasis has been placed on Child Survival activities including a major immunization initiative in the Expanded Program of Immunization (Programme Elargi de Vaccination -- PEV) supported by UNICEF and USAID's Combatting Communicable Disease Project (CCCD). This emphasis has been effective in increasing complete immunization coverage of children from 10% in 1984 to nearly 50% in 1989.

Togo is also experimenting with the Bamako Initiative, promoted by UNICEF. This Initiative includes a program to provide essential drugs and to develop cost-recovery mechanisms, particularly for village level pharmacies.

Family planning is emerging as a national priority, with draft policies developed, although no official commitment to a National Family Planning Policy has been approved. The MOH has a Family Planning Program which is active in a portion of the public health centers. The Togolese Family Planning Association (Association

Togolaise pour le Bien-Etre Familial (ATBEF), a local International Planned Parenthood Foundation (IPPF) affiliate, provides training for health providers in both the public and private sectors, contraceptives, and clinic services. Coordination between the two programs has not been very successful.

The Health and Population Project which is being negotiated for a World Bank sector loan has led to the articulation of a new Proposed National Health Policy. This policy statement has placed first priority on Maternal and Child health (Santé Maternel et Infantile --SMI) and Family Planning -- including Safe Motherhood, PEV, control of diarrheal diseases (Lutte contra les maladies diarrhéique -- LMD), nutrition, acute respiratory infections (infections respiratoires aiguës -- IRA), and Family Planning -- followed by Malaria, tuberculosis, parasites, sexually transmitted diseases and AIDS, dental health, ophthalmology, cardio-vascular diseases, and the environment. It has also expressed commitment to essential drugs, collaboration with private sector, strengthening information, education and communication programs (IEC), and training.

The proposed policy has established the following targets for 1995: reduction in maternal mortality from 500 to 450 per 100,000 live births; reduction of anemia in pregnant women from 46% to 10%; increase Family planning services availability from 10% to 60% of women; increase contraceptive prevalence from 5 to 15%; reduce mortality from diarrhea by 70%; increase vaccine coverage to 90%.

The proposal also includes a commitment to an administrative reform of the Ministry of Public Health, with emphasis on integration and decentralization of administration and on developing cost recovery mechanisms. A commitment to the expansion of private health sector is also expressed.

D. Overview of Health Status and Health Resources

1. Health Status: High infant and maternal mortality rates, high incidence of infectious diseases, and high population growth remain major problems in Togo. The efforts made to date in the health sector have only marginally improved these statistics.

Most of the data on morbidity and mortality which we report here is based on reports from health centers. Since only a limited number of persons frequent the health centers, and then for only certain illnesses, and since diagnoses may be misclassified by inadequately-trained health personnel, these data are clearly serious underestimates of the health problems of Togo and are, as well, subject to some margin of error. Nevertheless, they do present a view of the relative importance of health problems.

The major diseases for which people consulted at health centers during 1989 were:¹ malaria (34 percent), trauma/wounds (10 percent), diarrheal diseases (8 percent), eye/ear infections (5 percent -- of which three-quarters are for conjunctivitis), and acute respiratory infection (4 percent). The incidence of malaria per 1000 inhabitants seems to have been rising since 1980, but given the irregularities of the information system, this may be an artifact of increased reporting rather than a real increase. Moreover, the diagnosis of malaria is most often a presumptive one, not confirmed by a blood smear. However, the increase of drug-resistant, and particularly chloroquine-resistant malaria, has been noted as increasing throughout the country. In 1989, hospitals reported 341 deaths from malaria, making it the major cause of death (14 percent of deaths).

Anemia as a cause for consultation constituted only 0.5 percent of consultations (11,588 cases in 1989), but among those hospitalized, it was the second cause of death (7.8 percent, 189 cases).

During 1989, 164 cases of tetanus (excluding neo-natal tetanus) were seen in outpatient clinics and an additional 157 cases were hospitalized for a total of 321 cases of what is basically a preventable disease. Deaths from tetanus were reported in 32 cases.

Since 1985, the number of reported cases of schistosomiasis has been between 3000 and 5000 annually. Other reported diseases of interest to health planners: onchocerciasis, 3773 cases (633 hospitalizations, no deaths reported), and dracunculosis (guinea worm), 561 cases, (1 hospitalization, no deaths reported).

Health risks for children are particularly high. Estimates of the infant mortality rate range from 81 to 130 per 1000 live births (see Table 1)². Whatever the actual rate, the figure are sufficiently high to know that the country has a major problem of infant mortality and that this requires continued attention.

¹ These figures are in proportion to total new cases at health centers.

² See Section II4d for a discussion of the quality of data available for these analyses.

Table 1

Infant Mortality Estimates, Togo (per 1000 births)

	1973-77	1978-82	1983-87
DHS, 1988	107	87	81
Census, 1981		130	

For children, as for adults, the major reason for consulting health facilities is malaria, accounting for 27.9 percent of consultations for children under one year old and rising to 31 percent for children aged one through four years old (See Table 2). In 1988, 43.2 percent of children under five surveyed had fever (presumed malaria) during the two weeks previous to the survey (DHS survey, 1988). This amounts to more than 10 episodes per child per year, a discouraging number. In 1989, acute respiratory infections are the second cause for consultation of children under five (16.7 percent), followed by diarrheal disease (14.3 percent). Again, in the DHS survey, 29.4 percent of children under five had experienced diarrhea during the past two weeks and 14.2 percent had experienced it during the past 24 hours. The fourth cause for consultation among children is conjunctivitis (7.2 percent), a disease which, if left untreated, can lead to more serious eye problems. For children under five, anemia also ranks as an important cause of reported consultations (6627 cases), hospitalizations (1481 cases) and hospital deaths (117 cases).

Measles and tetanus, two of the target diseases of the immunization program, PEV, serve as useful tracer conditions to monitor the effectiveness of this program. Reported measles incidence for all age groups throughout the country declined after 1985, with a slight rise in 1988 to 16,464 reported cases to a sudden drop in 1989 to 3489 cases. Among children under five the number of cases dropped from 11,541 cases in 1988 to 2347 in 1989. Since measles is a relatively easily diagnosed disease, this drop is probably a real one and, in great part, can be considered a satisfying result of immunization efforts.

Table 2

**Major Reasons for consultation at Health Centers, 1989
New Cases Reported of Children under Five Years**

A. Percent of Total New Cases			
DISEASE	AGE		
	Under One year	1-4 years	TOTAL 0-5 years
Malaria	27.9%	33.0%	31.0%
Respiratory Infection (upper and lower)	21.8	13.4	16.7
Diarrheal Diseases (including amoebiasis)	15.8	13.2	14.3
Conjunctivitis	9.2	5.9	7.2
Trauma/wounds/burns	6.5	8.9	7.9
TOTAL number of cases	289,959	430,099	729,058

B. Numbers of Cases of Selected Important Diseases			
DISEASE	AGE		
	Under One year	1-4 years	TOTAL 0-5 years
Tetanus, neonatal			
Consultations	55		
Cases hospitalized	<u>20</u>		
TOTAL	75		
Tetanus, other			
Consultations	18	29	47
Cases hospitalized	<u>6</u>	<u>6</u>	<u>12</u>
TOTAL	24	35	59
Measles			
Consultations	541	1537	2078
Cases hospitalized	<u>84</u>	<u>185</u>	<u>269</u>
TOTAL	625	1722	2347
Anemia			
Consultations	1496	3650	5146
Cases hospitalized	<u>514</u>	<u>967</u>	<u>1481</u>
TOTAL	2010	4617	6627

Source: Statistiques Sanitaires, 1989

Tetanus is a preventable disease for a neonate if the mother has received at least two doses of vaccination, and for a child if he has received three doses of DTP at the appropriate time intervals. Despite considerable efforts to obtain coverage of all women of child-bearing age (coverage estimated as over 60 percent with 20 percent of women having received their second dose during 1989), 75 cases of neonatal tetanus were reported during 1989. Meanwhile, there were 59 reported cases of tetanus among other children under five.

Since the end of the drought in 1985, malnutrition in Togo is mainly chronic, not acute. The DHS Survey of 1988 identified 30.6 percent of the children as chronically malnourished (height for age), but only 5.3 percent as acutely malnourished (weight for height).

Maternal mortality rates are high, estimated at 700 per 100,000 deliveries, an average derived from two earlier studies. In 1989, 63 maternal deaths were reported out of a total of 9056 deliveries from maternity hospitals, giving a similar rate of 655 per 100,000 deliveries.³ Whether these maternal deaths in hospitals reflect the true rate in the country is hard to assess. Outside of Lomé, only a small proportion (7 percent) of Togo's births are reported to take place in health centers or are attended by health workers. The death rate of those hospitalized could be biased on the high side since it could be that mainly women at higher risk are hospitalized. On the other hand, there is so little access to health care in certain regions of the country, that the maternal deaths could be high in those areas and totally unreported.

In Lomé, the capital, the number of deliveries in public hospitals rose from 16,353 in 1987 to 18,175 in 1989. This represents about three-quarters of all births.⁴ According to a study conducted at the University Hospital, the major risk factors for maternal death are infections, hemorrhage, induced abortions, and eclampsia. One

³ Source: Statistiques Sanitaires 1989. Figures are derived from all reported hospitalizations and deaths related to pregnancy, specifically: normal delivery, unspecified infection relating to pregnancy, abortion, cesarean, dystocia, puerperal infection, placenta previa/hemorrhage, pre-eclampsia/eclampsia, retained placenta, uterine rupture.

⁴ Centre de Santé-Maternité de Bé, Documentation Statistique, 1989. This center itself was the site of 3671 births in an area with an expected 6750 births. Since some mothers are delivered by private physicians, midwives, and birth attendants and since their activities are unreported (and unsupervised) these figures is probably an underestimate of the number of attended deliveries.

of the major causes of morbidity is anemia. According to a OCCGE nutrition survey in 1985, 48 percent of pregnant women (at nine months) are anemic.

Total fertility has been variously estimated since 1960 as 6.4 in 1961, 6.6 in 1971 (Demographic surveys) and 6.0 in the 1981 census (which is considered to be an underestimate). The 1988 DHS survey estimated total fertility at 7.08 per woman during her lifetime. The urban areas were lower (5.83) compared to rural areas (7.51). This is a high rate which tallies closely with the growth rate observed by the 1981 census of 2.9 percent (4.4 percent for the urban populations; 2.4 percent for rural populations). This rapid growth of the population, unless moderated, could put a severe strain on Togo's already pressed economic and social resources.

2. Health Resources: The Ministry of Public Health is the dominant employer of health personnel and manager of health facilities in the country. In 1989, it employed 5236 persons, down 7.0 percent from two years earlier. Of this staff, which includes administrators and clinicians, 60.1 percent work in the periphery, outside the capital city, although the periphery accounts for 86.2 percent of the population. The Ministry has made some effort to redress the balance since 1987 when the periphery received only 55.9 percent of health workers.

Table 3

Health Personnel, Togo, 1987, 1989

Personnel	1987	1989	Percent Change 87-89
Total Public	5631	5236	-7.0%
Lomé	2501	2089	-16.5
Periphery	3130	3147	+0.5
% Periphery/Total	55.9%	60.1%	
Total Private	52	244	369.0%

Source: Statistiques Sanitaires, 1987, 1989

public sector: 52.4 percent of physicians work in Lomé health centers, 57.1 percent of dentists, 40.5 percent of medical assistants, 41.6 percent of midwives. Even among qualified nurses, 25.9 percent are to be found in Lomé (Table 4).

TABLE 4
Clinical Personnel (Selected Categories)
by place and type of practice, 1989

Public Sector -----	Asst					Total
	MD	Dentist	Med.	Midwife	Nurse	
Lomé Health Centers	85	4	41	112	271	1,542
Periphery in clinical practice	77	3	60	157	775	3,147
Total	162	7	101	269	1,046	4,689
% clinical personnel in Lomé	52.4%	57.1%	40.5%	41.6%	25.9%	32.9%
Private Sector -----	86	7	1	25	16	244
Total in clinical practice (public and private)	248	14	102	294	1,062	4,933
% clinical personnel in Lomé and large towns (public and private)	69.0%	78.6%	41.1%	46.6%	27.0%	36.2%

Source: Statistiques Sanitaires, 1989

Meanwhile, the private sector has grown considerably, particularly in the case of physicians, dentists, and pharmacists, who constitute respectively 31.0, 61.1, and 64.6 percent of the total personnel in Togo (see Table 5). The private sector is minimal for other categories of personnel (7.1 percent midwives, 1.4 percent nurses).

TABLE 5
Selected Personnel in Health Sector, 1989

	Qualified Medical Personnel					
	Physician	Dentist	Pharmacist	Assistant	Midwife	Nurse

Public Sector						

Centers outside						
Lomé	77	3	9	60	157	775
Central Ministry						
and Lomé	114	4	14*	68	169	321
Total Public	191	7	23	128	326	1,096
Private Sector						
-----	86	11	42	1	25	16
TOTAL HEALTH SECTOR	277	18	65	129	351	1,112

% Private/Total Health Sector	31%	61.1%	64.6%	0.8%	7.1%	1.4%

* Includes 6 at Togopharma

Source: Statistiques Sanitaires 1989

In adding the private to the public clinical personnel, the proportion of health workers who work in Lomé and other towns rises to 36.2 percent, with physicians (69.0 percent), dentists (78.6 percent), medical assistants (41.1 percent), midwives (46.6 percent), and nurses (27 percent).

Thus, despite the Ministry's recent efforts to emphasize the rural areas in primary health care, the growth of the private sector has meant a continued favoring of the urban areas in regard to access to health services.

To assess the number and type of health facilities in Togo proved a challenge. We were unable to locate a nominative list of all health facilities by affiliation and by type. Attempts to categorize facilities by type proved difficult because the Ministry has no standard nomenclature for them -- or rather, several systems of appellation are used. Thus, what the Administrative bureau (from whom we received a count of health facilities) lists as a secondary care center is what others in the Ministry refer to as a primary care center or dispensary. Further confusing is that the Statistical Yearbook for 1989 shows 30 hospitals, while the administrative division's table shows only 25.

We were unable to resolve these confusions during our consultation and recommend that the Ministry make a priority to develop a nominative list of health facilities with, as a minimum of information, their type, affiliation, legal status, and bed capacity. Meanwhile, we can only estimate the facilities: one University Research Hospital, four regional hospitals with full surgical capacity, 20 prefectoral hospitals, with perhaps 7 sub-prefectural hospitals. In addition, there are at least three major hospitals supported by the Protestant or Catholic churches. Below that are public health centers and dispensaries staffed by nurses which number over 300. All these centers are said to provide maternal and child health preventive care, as well as curative care. There are an additional unknown number of such facilities under religious and private auspices.

Nationwide, there are 5307 hospital beds or 1.6 beds per 1000 population. Twenty-three percent of these beds are at the University Hospital in Lomé; 37 percent of all hospital beds in Togo are in Lomé and its surrounding prefecture.

The Statistical Yearbook for 1989 lists 48 private pharmacies and 86 sales depots of Togopharma.

II. STRUCTURE OF HEALTH SECTOR

The health sector is characterized by a multiplicity of public and private institutions, programs, and activities. In this section we will first focus on the major actors and the relationship of these institutions to the Ministry of Public Health. We will then analyze the existing organization of the Ministry. We then examine its information system, its plans for reorganization, and how this proposed reorganization can provide opportunities for resolving some of the most pressing issues: integration of vertical programs; development and utilization of reliable information systems for management and planning; and decentralization to permit local area planning. We conclude with an analysis of the prospects for the institutionalization/sustainability of the Ministry's activities.

A. Institutions in the Health Sector and Their Inter-Relationships

The Ministry of Public Health is the major actor in the health sector. It controls most of the health facilities and employs directly most of the personnel (see ID for public/private breakdown of personnel). The Ministry is involved in almost all health interventions, from sanitation and vector control to direct delivery of health care.

Several other Ministries also play significant roles in the health sector. Until February of this year, there was a single Ministry of Public Health, Social Affairs and the Condition of Women. Despite this union, each unit operated quite independently through its own directors-general. When the Ministry split in two, in February 1990, all health and family planning services remained as they had been, in Public Health. However, the Ministry of Social Affairs the Condition of Women still has some health-related activities. Through its social centers (CNI) throughout the country (which are often housed adjacent to health centers), this Ministry provides services to women and children including health education, nutrition and feeding programs. With the Ministerial reorganization, it remains to be seen exactly what will be the relationship of social centers which carry out nutritional surveillance to Ministry of Public Health centers with the same activities. Public Health Ministry officials believe that mothers and children are more likely to go to the social centers where food is also distributed (thanks to the CRS program) than to the health centers where a broad spectrum of preventive and curative care is available.

The Public Health Ministry provides curative health services in the schools run by the Ministry of National Education. It also

provides health education for these students, stressing preventive care. It assures that its immunization program reaches students by dispatching teams to vaccinate in the schools.

Two other Ministries play important roles in the development of Ministry of Public Health programs. The Ministry of Finance sets the ceiling for the Ministry's recurrent budget. During recent years these ceilings have been held to the same levels. The process appears to be that of a fiat emerging from the Ministry of Finance, rather than that of a negotiated agreement. The Ministry of Plan does the same for the investment budget. Equally important is the practice of having the Ministry refer to the Ministry of Plan any proposals/projects which might have political implications or prove the slightest controversial. If approved by the Ministry of Plan, these are eventually reviewed by the council of ministers with the final decision made by the President. This becomes a slow, cumbersome process in which the projects/proposals can be lost. For example, the policy statement for the Family Planning program which was circulated in February, was sent to the MOP in March. At present, it is not clear that any action has been taken at that level. Any construction which the Ministry of Public Health needs done, is actually carried out by other ministries, Plan or Rural Development. On a smaller scale, certain expenditures by the Ministry of Public Health (e.g. construction materials) are reviewed by the Planning Ministry creating a high degree of centralization in the Government and decreasing Ministry of Public Health autonomy to manage its own activities.

Outside the Ministry, at least 20 organizations work in the health sector. Several religious organizations sponsor health centers which deliver services directly to the population. The larger religious hospitals are as follows:

- Hôpital Bethesda, at Agu-Nyogbo in Kloto Prefecture managed by the Eglise Evangélique of Togo (the hospital also supports village health workers in the surrounding communities)
- Hôpital St. Jean, at Afagnan, Lac Prefecture (Catholic)
- Hôpital St. Luc, Pagala, Sotouboua Prefecture (Catholic)

In addition are many smaller health centers sponsored by Protestant and Catholic churches. These health facilities comprise only a small part of the health facilities in Togo, but they are influential. The local populations often use them in preference to public ones in the belief that their care is superior (something which several observers confirmed is true). They also provide necessary medications without extra charge which saves the patient

the prescription costs he would incur if he attended public facilities. They also charge for contraceptives. These hospitals charge fees but do not follow the fee schedules of public hospitals. They have an advantage over public hospitals in that the funds collected stay at the institution, whereas public facilities must return their receipts to the Treasury. This year, for the first time, the National Health Statistics Services (SNSS) is trying to include these facilities in its monthly reporting system for immunizations, PMI, and hospitalizations. Until now, their activities and the diseases they treat have not been included in national statistics.

The ATBEF, a non-profit affiliate of the IPPF, has played a special role in the development of family planning programs. With the support of USAID it runs a family planning clinic in Lomé and a USAID-supplied distribution system for contraceptives to public sector depots around the country. At present, it is the main supplier for contraceptives to public and private facilities. ATBEF also has trained 15 "motivatrices" whose task in the field is to make the population aware of family planning and to distribute non-medical contraceptives (condoms and spermicides). The ATBEF collects data on contraceptive use from the centers it supplies. Until now, this data collection system has not been coordinated with the Ministry of Public Health. In fact, the relationship between ATBEF and the MOPH's family planning program (PNBEF) has been competitive rather than cooperative. As the public program develops, it will take over some of the ATBEF's activities, such as contraceptive distribution and data collection in health facilities, while the ATBEF plans to turn its energies more strictly toward working in the private sector.

Most donors work through existing public institutions by providing technical assistance, training, construction, and equipment. In terms of fiscal contribution, the major ones are USAID, UNICEF, UNFPA, World Health Organization, and GTZ. Among the smaller donors are CRS, Croix Rouge du Togo, FAC, FED, CUSO, and Peace Corps. The larger donors, particularly, have strongly influenced the MOPH by assisting it to construct, rehabilitate, or equip facilities and to develop high priority programs such as malaria control, immunizations, diarrheal disease control, and family planning. Many of the smaller donors have focussed on the village level to encourage village development committees, to train village health workers, and to build health posts.

Drugs, in Togo, are available through the public, private commercial and non-profit sectors. Almost all drugs are officially imported by the para-statal monopoly, Togopharma. The MOPH contracts through its own agency, Pharmapro, to purchase a limited list of essential drugs from Togopharma. Togopharma also has 8 pharmacies and 91 sales depots in rural areas. Among the 48 commercial private pharmacies in Togo (all supplied by Togopharma), 73 percent are in the capital, Lomé. Drugs are also available for

purchase in any local market. USAID provides contraceptives to the ATBEF, making it currently the main supplier in Togo. UNFPA also provides contraceptives to ATBEF. Other NGOs donate drugs to public or private organizations. A few charitable hospitals, as well as the GTZ project in the Central Region, purchase their own drugs directly from Europe rather than passing through the higher-priced Togopharma.

The organization of the drug supply is a matter of concern to the Government. The management at Togopharma and Pharmapro have been frequently criticized by Ministry officials. Inadequate management has resulted in disruptions in the semi-annual drug deliveries to health centers. Another issue is the prescribing and use of inappropriate and expensive drugs. In April, the Ministry published lists of "essential drugs," most of them generic, to be prescribed by health workers at the different levels of the health system. Togopharma is being asked to stock these drugs regularly in preference to the name brands used earlier. The Ministry hopes that by using the essential drug list and by using generic drugs, health workers will begin to choose treatments that are more appropriate and that will be of lower cost to the patients and to the Government.

The MOPH regulates the establishment of private medical and midwifery practice and the establishment of clinics and pharmacies. A technical committee within the Ministry reviews qualifications and presents its recommendations to the Minister. Once the MOPH approves a health professional or clinic, it does not further regulate nor monitor activities. In 1989, 86 physicians were reported in private practice, nearly all in Lomé. This figure is probably an under-estimate of actual practice for two reasons: first, some private physicians may open practices without official sanction; second, if anecdotal information is to be believed, some publicly-employed physicians may carry on a small private practice on the side.

B. Organization of the Ministry of Public Health

1. Centralization: The Ministry of Public Health is characterized by a hierarchical structure which centralizes decision-making at the very top, with the Minister and his Cabinet Director. At every level of the Ministry, decisions are moved to a higher level until someone is able and willing to make the decision. This is rarely anyone other than the Minister. In 1989, when the Ministry created its Planning unit (UPC-Unité de Planification et Coordinations), it was placed at the level of the Cabinet Director. The UPC had been formed to meet the terms of a grant agreement with USAID which would provide assistance to the Ministry to plan and program its activities. In the year since its creation, the UPC has, in fact, done little planning for the Ministry, and was not a major actor in the drafting of the analysis

which the Ministry prepared for the World Bank. The UPC was conceived as a planning unit for a Ministry that had a tri-partite structure (Health, Social Affairs, and Condition of Women), but with the splitting off of two of these units in February 1990, the purposes of the UPC seem to have become mooted since Health is now the only relevant Ministry. Thus, the UPC is in a kind of administrative limbo, removed from operational levels. The ultimate effect of centralization at the highest levels is to render the planning unit ineffective.

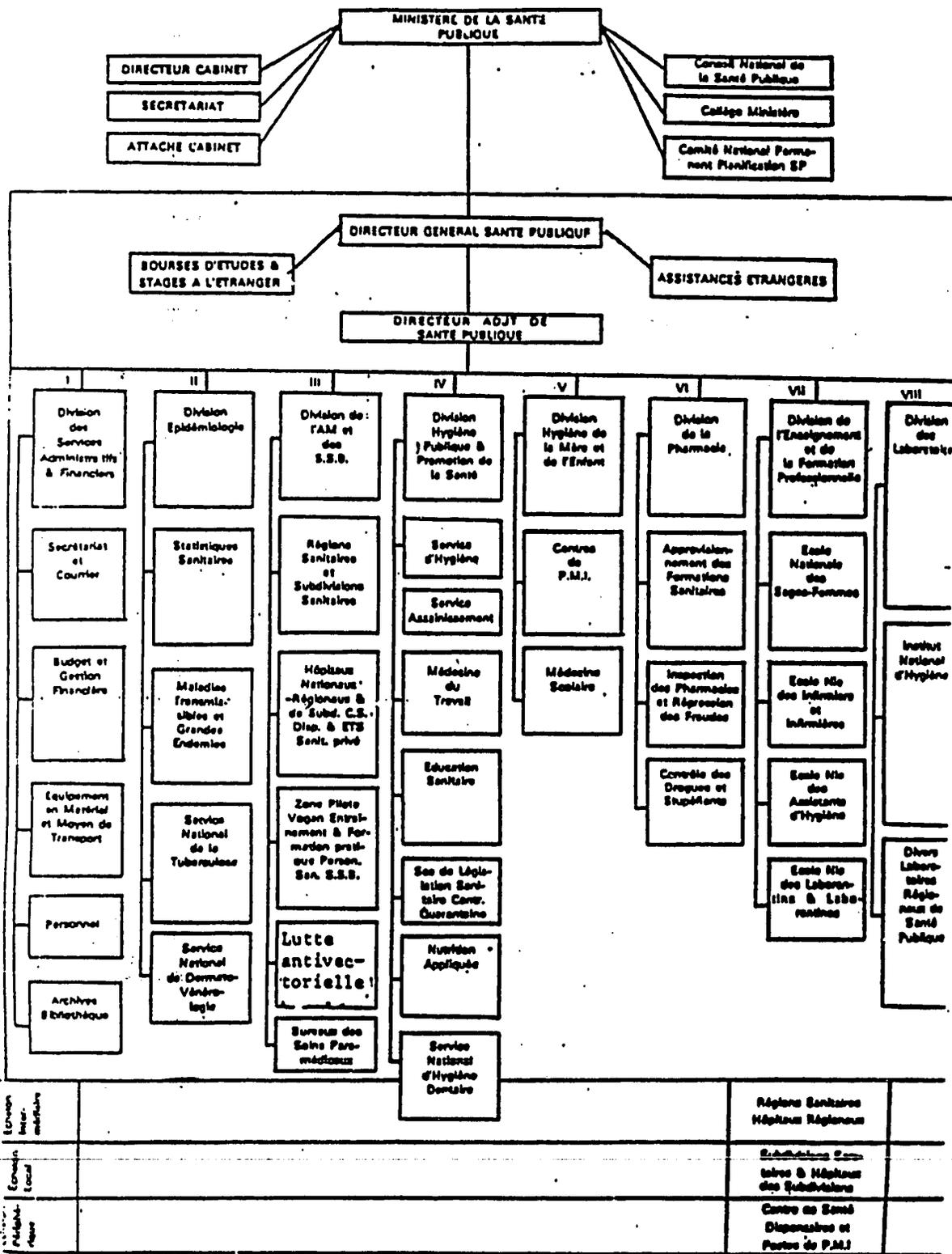
The extent of Ministry centralization is also illustrated by an incident we witnessed where the Cabinet Director called directly a division director to inform him of where a new health/social center was to be placed. There was no discussion of criteria for implantation. Nor did the decision pass first to the Director General, the chief technical person in the Ministry. The Director General, in turn, oversees eight divisions (directorates) which are, in turn, divided into sub-bureaus (see Figure 1).

The present structure was established in 1969. It retains vestiges of French colonial administration, in particular, its emphasis on endemic diseases and on curative activities mainly in the towns. The eight divisions grew up gradually with their respective sub-units assigned in terms of the logic presented at the time. Thus, some of the divisions have a general cohesiveness; others represent a hodge-podge of programs and services. The Division of Administrative and Financial services oversees the budget and personnel, and manages equipment. Personnel decisions, however, are made by the Minister.

The Division of Epidemiology is responsible for the PEV, which is logical in terms of epidemiology, but illogical in terms of it being a program directed at mothers and children, and therefore possibly more at home in DME. Epidemiology houses the venerable bureau of Grandes Endemies whose former functions seem to have been distributed among a series of disease-specific services, such as tuberculosis, leprosy, and malaria. Finally, Epidemiology is the repository for the Ministry's statistics services (SNSS). This explains perhaps, in part, why this unit focusses its reporting efforts mainly on disease and immunization reporting. The National Malaria Services is officially in this Division, but we were also told, it is not really in, having a status of its own.

Figure 1

Organization Chart Ministry of Health, Togo



The DME (Division of Mother and Child) oversees preventive maternal and child health programs including diarrheal disease, nutritional surveillance, safe motherhood, and family planning. The activities are carried out by health centers. Since it has recently received a computer through the CCCD program, it will begin to be able to process its own data. The Division of Public Hygiene and Health Promotion runs the country's sanitation programs, occupational medicine, and health education programs. It is the one Division in the Ministry which has officials at the regional level. Health education is handled by the SNES (Health Education Service), which works closely with the regional and local sanitation officers (also in the division), but also with the many different programs engaged in health education.

The Division of health infrastructures (l'Assistance Médicale et Soins de Santé de Base) oversees the health subdivisions and health facilities. The remaining three divisions are those of Pharmacy, Laboratory, and Professional Education and Training.

2. Verticalization. As the Ministry added new activities, usually at the behest of donors, these were established in newly created program units. Thus, the Ministry now has national programs for malaria control, tuberculosis control, leprosy control, immunizations (PEV), Maternal and child health prevention (PMI), family planning (PNBEF), diarrheal diseases, and, most recently, AIDS. In child survival activities, no single division houses all the relevant programs. The PEV is a major child survival activity but it is in the Division of Epidemiology. When PEV trains local health workers to carry out the technical tasks of immunizing mothers and children, it does not coordinate that training with SNES's training of health workers to educate mothers about immunization schedules. The National Malaria Service is an organizational oddity. It parallels several other divisions and services, carrying out research, laboratory analysis and control, drug distribution, and information gathering -- only for malaria.

Some support activities that are cross cutting -- such as training and health education -- should be separate units since they provide a service that is needed by many different types of programs. However, the vertical organization of the ministry has undermined even these cross cutting and potentially integrative programs. SNES is often bypassed in intervention-specific training programs and in the development of health education materials.

Donors compound the problem of verticalization by mandating that special units be created to focus on the intervention of their choice. This, in turn sets up a competition among the donor-supported programs as to which will dominate in which domain.

The Ministry has attempted to overcome the problems engendered by verticalization by establishing inter-sectorial commissions of

coordination. Four such sub-commissions have been formed, on infectious diseases, health education (IEC), nutrition, and safe motherhood. Although the commissions have been meeting bi-monthly, we were told that so far, this mechanism has not been successful in forging coordination because the commissions have no power.

A vertical structure may have advantages when a new program is launched because it permits the Ministry to concentrate its activities. However, the continuous use of such vertical programs creates serious operational problems, since the same few workers at the service delivery level are required to deliver services in all programs. Thus, the vertical programs compete for the health workers' attention. He is drawn from one strategy to the next. We were told, for example, that when PEV conducts its immunization campaigns, the normal services in health centers, as well as in the other programs, are disrupted. A second disadvantage of vertical programs is the duplication of activities. Local health officials commented to us on the endless round of seminars which have passed their way, first on diarrheal disease, then on immunization s, then on malaria. Médecins chefs learn how to supervise the immunization program, but not how to do general supervision and monitoring of local health workers.

A final disadvantage of vertical programs lies in the inefficiencies they engender for the existing information system. Each program adopts reports for its own purposes without consideration of the burden on the local health worker nor of the duplication possible, nor of the management needs at local and regional levels.

In summary, the local health workers who are responsible for delivering services often find it impossible to coordinate, much less to integrate, the disparate programs which the central Ministry, itself is unable to integrate.

3. Hierarchy and Bureaucratic Culture: The administrative reorganization of 1969 called for the establishment of five regional offices with a director. In fact, this was never implemented although the Health Education (SNES) and Sanitation program bureaus did place personnel in a few regions. Thus, the effective administrative units in the field are the 21 health subdivisions which are consonant with the administrative préfecture, and nine subprefectures. The administrative head of the sanitary subdivision is the médecin-chef who supervises all health activities in the préfecture. This turns out to be a formidable task because the médecin-chef is, as well, usually the sole physician in the préfecture and the administrator of the préfectoral hospital. The médecins-chefs we interviewed found that although they attempted to set aside two days a week for supervision of outlying clinics, in fact, they rarely had time even for one day. Most of their time was spent in clinical work. In addition, they organize monthly meetings with the nurses and

midwives in the outlying dispensaries; they hold weekly staff meetings within their hospital; they review all reports; they make supervisory trips; they plan and manage the budget for the subdivision; and they respond to the prefects' needs in times of emergencies.

Despite their many responsibilities, *médecins-chefs* have little autonomy and support to meet them. Their small budgets for gasoline, maintenance, and minor repairs, and medications have increased only marginally over time; they have no staff for their administrative tasks; they are constrained to stay within the line items of their budget; the vehicle fuel line-item of the budget is small and limits their ability to make supervisory trips; all staffing decisions are made by the Minister, himself; repairs to equipment and facilities are determined by the central Ministry; finally, few of these *médecins-chefs* have been trained in public health and administration, the skills they need to carry out their jobs.

The centralization of the Ministry within the upper directorate thus extends to local administration as well. It discourages initiatives by a group of astute *médecins-chefs* and closes the door to local area planning. Although these *médecins-chefs* have the opportunity to present their needs to the central Ministry, under the present system they rarely receive a response, much less the resources. At no level of the government, were we able, in our interviews, to discern the rationale for the allocation of resources, such as personnel. The response was always that it was the Minister's decision.

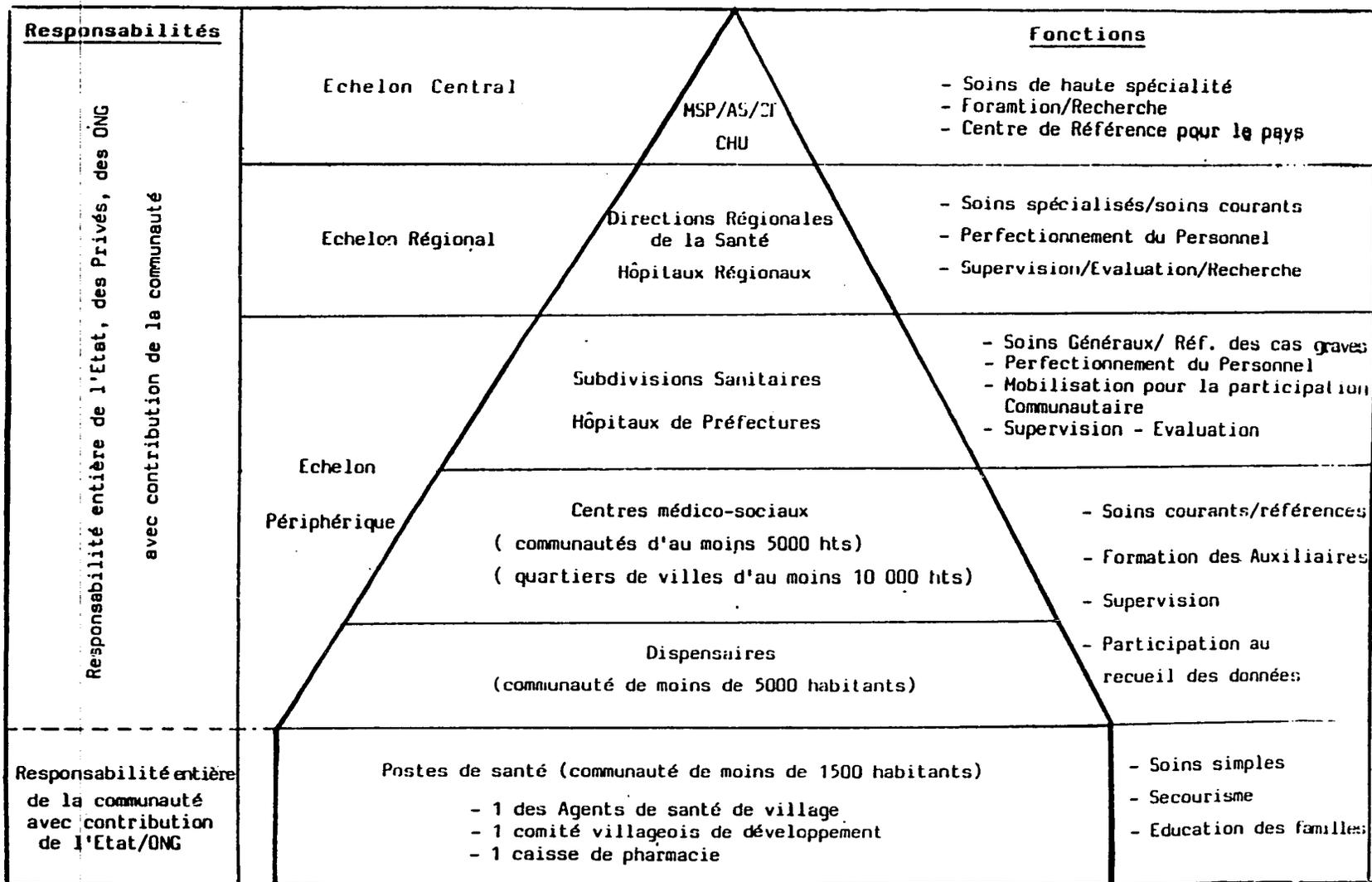
The high degree of centralization creates a bureaucratic culture where the cardinal rule is "the boss is always the boss." In such an environment, even when the personnel at the lower level are highly competent, they have no incentive to take initiatives. This then limits the organization's absorptive capacity to initiate new programs, or even, to reorganize the way it does its work.

The organization of health facilities follows the administrative structure of the country as a whole. Figure 2 shows the organization of these facilities as the Ministry envisages them for the future. The tertiary care facility, the University Hospital in Lomé (CHU), is the reference center for the whole country. Below it are the four regional hospitals with the CHU serving also as the regional hospital for its region. These facilities are those capable of performing surgery. Below the regional level are 20 hospitals, one for each health subdivision (prefecture). Again, the CHU serves as the subdivision hospital for Lomé. All of these facilities are headed by a physician.

Figure 2

LE SYSTEME DE SANTE AU TOGO DES ANNEES 90

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Below these secondary care facilities, the picture of primary care facilities becomes less clear. Figure 2 shows medical-social centers in towns of more than 5000 inhabitants. These are health centers where the social services personnel from the Ministry for Social Affairs and Condition of Women and health personnel from MOPH work in the same buildings. We were told, however, that at present such structures exist only in a few towns. In fact, the table shows the intended system, rather than the present one. What appears to be true is that most subprefectures have centres de santé (medical centers) headed by, at least, a medical assistant (assistant médical). All these centers have hospital beds. Finally, below this level are the dispensaries headed by a nurse and usually assisted by a birthing attendant (accoucheuse). Some dispensaries also have hospital beds, used particularly for deliveries.

The exact number of primary care facilities described in the paragraph above is not readily available. We were given estimates of 315 to 320, but these figures include as well health posts not under the MOPH. We were unable to obtain a nominative list of MOPH health facilities during our interviews in the Ministry. Several officials suggested such a list probably did not exist; others suggested the director of personnel might have one. Some of the difficulty in getting a clear idea of the number and type of health facilities is caused by multiple and overlapping, or even contradictory, definitions. Despite what is shown in Figure 2, the MOPH has at present no clear classification system for health facilities. For example, in some documents, a dispensary is called a secondary care center while a more sophisticated health care center at the subprefecture level is called a primary care center, just the opposite of what one would expect. The lack of a classification system complicates any attempt at planning the allocation of resources.

Health facilities and services extend below the level of MOPH dispensaries. Until now, the SNES of MOPH has been the sole MOPH participant in community mobilization, development of village health committees and health posts, and training of village health workers. Most of these activities are undertaken through the support of donor organizations.

At present, village health workers have no formal relationship to Ministry facilities and personnel. Information about their activities is not collected by the Ministry. The médecin-chef, for example, does not (nor is he expected to) supervise village health workers. Nor are dispensary nurses responsible for supervising the activities of village health workers within their catchment area, though some may do so on an ad hoc basis. This situation breaks the links among operational units of the health sector. In implementing its strategy for primary care development, the Government has not yet created a means to tie the newly created

village health workers with the dispensaries, their points of reference. This task for the MOPH is best accomplished through support of local médecin-chef supervision rather than through central Ministry management.

4. Information System:

The Ministry's information system reflects the unfortunate results of excessive centralization and verticalization. Rather than being an instrument for integration of Ministry efforts in planning and management, it serves as an instrument of fragmentation. Nevertheless, the information system today has improved considerably over what it was five years ago when it was evaluated unfavorably by a CDC consultant.

The Ministry draws its information from three sources: routine reports from health facilities; periodic surveys and special studies; and the census. The routine reporting system is highly developed, complex, and cumbersome. Although it has some elements which are functioning well, much of the data are of uncertain quality.

a. Routine Reporting System:

Every health facility, from the dispensary on up, fills out monthly reports for the Ministry. These are sent to the médecin-chef who reviews them and sends them to the appropriate Directorate in the central Ministry for processing and analysis. Every health center providing outpatient curative care and preventive MCH services (which means virtually all facilities), each month fills out for the Ministry at least five reports from one to three pages long. These reports represent the activities of the vertical programs. They are as follows:

-Relevé Mensuel de Maladies (monthly disease report): New cases of 50 itemized diseases (WHO classification) seen during outpatient consultations (2 pages). The data are reported by sex and by each of 5 age groups. Prepared for the Statistics Bureau of the Epidemiology Division

-Therapeutic and prophylaxis use of chloroquine: New cases of fever, deaths, chloroquine utilization (2 pages). Prepared for the National Malaria service;

-Diarrheal diseases report: New cases of diarrhea, dehydration, deaths, and treatment delivered (1 page). Prepared for the Diarrheal Disease program in the DME

-Prenatal/postnatal consultations/births: New and old consultations for prenatal care and newborn care; mothers at risk and referrals by three age groups; births. Prepared for the SMI program of the DME (1 page)

-Immunization s: Doses administered by vaccine and by age group, doses of vaccine in stock (1 page). Prepared for the Epidemiology Division which sends it to the statistics bureau.

The 40 centers which provide family planning services use an additional report. Those centers which receive contraceptives from ATBEF prepare a stock report sent directly to the ATBEF. The PNBEF has also introduced a new report which, so far, is being used in only one prefecture. Finally, the newly-introduced growth-monitoring program is now adding a report (fortunately a simple one).

Nurses collect data for the first three reports listed above from their register of curative consultations. In order to complete the reports, they must page through the months's consultations three times, once for each report. Nurses, midwives, or birth attendants maintain registers or notebooks for each of the other program areas: prenatal consultations, postnatal consultations, births, and immunizations. Preparing reports is a time consuming task for health workers. In a large center, this preparation can take 7 person days.

The present reports were, for the most part, introduced this year, so it may be early to evaluate their reliability, accuracy and completeness. They do, however, represent improvements over previous forms. The relevé mensuelle, for example, considerably cuts down the number of reportable diseases to a manageable number and therefore should improve reporting. The new family planning information system packet with related patient record and monthly reporting form includes also an instruction manual.

In the field we saw what makes the system work and not work. First, health workers are assiduous in maintaining records of some sort. They do fill out reports and send them in. But they do not know why they are doing so, nor why there are so many. They carry out the task mechanically and are unaware that some of the data they collect could assist them in managing their own health centers.

We also observed many problems which cannot readily be solved simply by improving the format of the reports themselves. The reliability and accuracy, particularly of data from the curative consultation register is suspect. There is no national guide to classifying diseases, particularly one geared to nurses who diagnose probably more than 90 percent of the cases. Nurses have little or no access to diagnostic tests and have fewer clinical skills than the physicians for whom the WHO classification system is intended. Therefore, nurses tend to diagnose quickly on the basis of signs and symptoms which are not standardized. For example, lack of a standard definition for malnutrition resulted

in 1989 of a single clinic accounting for 90 percent of the malnutrition cases in Togo!

Since register formats are not coordinated with report formats, health workers are hardpressed to transfer data accurately. Data may therefore get lost, miscounted, or misattributed. Much of the data which is carefully recorded is never used. The sheer volume of work decreases the probability that even the most conscientious health worker will fill out these detailed documents accurately.

What is striking in observing the work of health centers is the fragmentation of the work in time and space. Prenatal visits may be on one day, postnatal visits on another. One room is used for immunizations, another is for growth monitoring. Yet, these are the same mothers and children who frequent the facility and they are the same nurses, midwives, and birth attendants who provide the services. Even the physical layout of many of the older clinics calls for different rooms for different programs. The information system, in itself, drives this fragmentation by demanding that each type of activity be recorded in its own register or notebook, usually kept in separate locations.

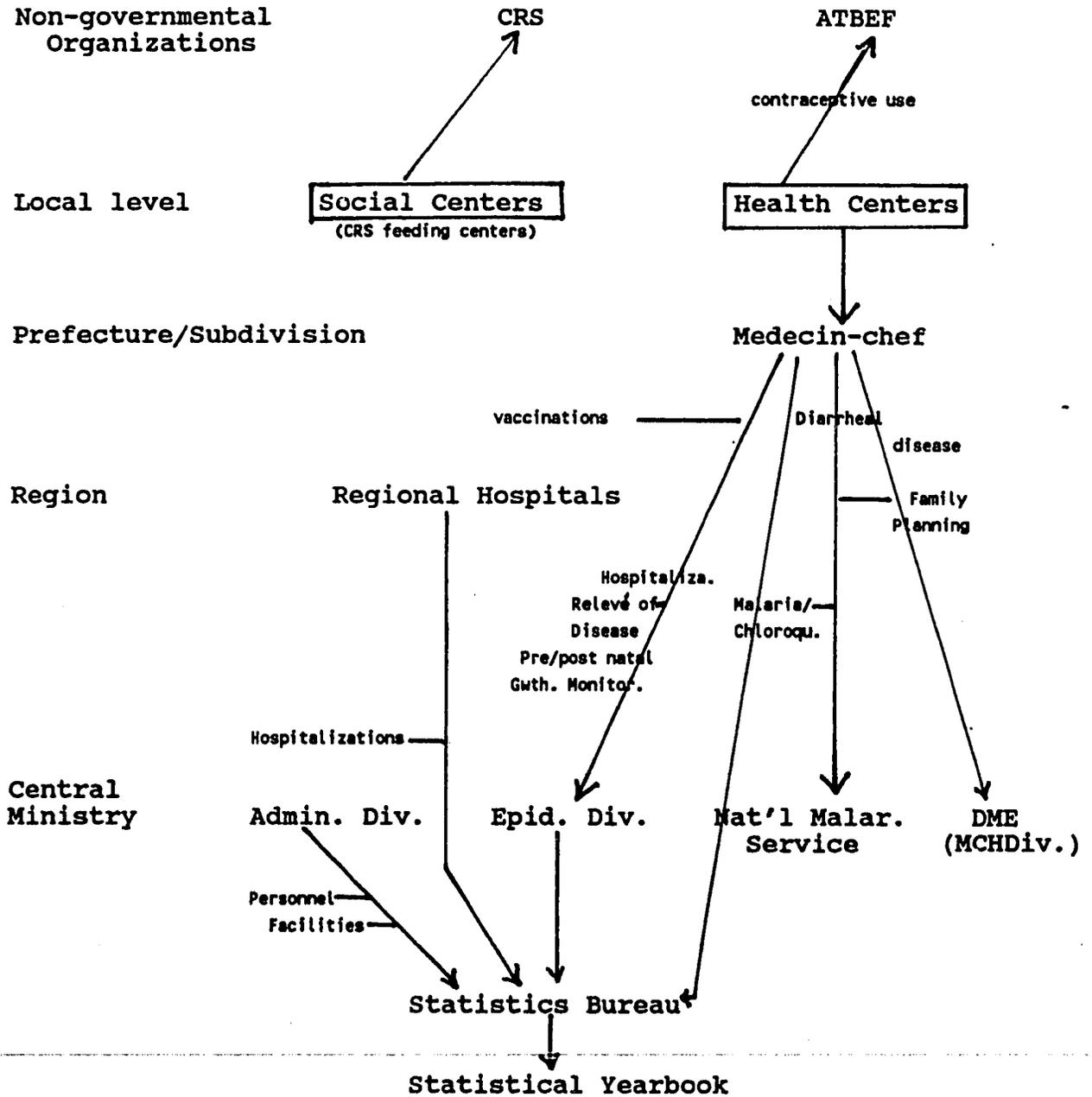
Health centers with hospital beds send a monthly report of cases discharged that month to the Statistics Bureau (via the médecin-chef). The data collected include the discharge diagnosis and whether death occurred. The statistics bureau in the Epidemiology Division will assign the appropriate WHO code. This form is also new this year and should permit more appropriate classification of disease if hospitals write in correctly a full diagnosis and if the statistics bureau personnel are well trained in medical coding.

Whether there is double counting of outpatients who are referred for hospitalization is unclear. We were told that when the clinic is in the hospital, there is no double counting. Otherwise, there may be.

All hospitals send their outpatient and inpatient reports to the médecin-chef. The exceptions to this rule are the regional hospitals which send their reports directly to the central Ministry. At present, médecins-chefs say they scan the reports only to make sure that they look reasonably well prepared and to identify important trends in disease. The médecin-chef, had he the time and the training, and were the reports sufficiently management-oriented, could use them to plan and manage the health resources in his subdivision. For example, he could analyze the extent of preventive activities compared to curative activities; total consultations compared to available personnel; and target areas where health workers were carrying out low volumes of preventive services compared to the population.

Figure 3

Flow of Information--Inpatient and Outpatient Monthly Reports



The flow of reports becomes complex once they leave the hands of the Médecins-chefs. This is illustrated in Figure 3. Immunizations, the Relevé of diseases, immunizations, pre/postnatal consultations, growth monitoring, and hospitalizations go to the Statistics Bureau of the Epidemiology Division. Regional hospitals also send their inpatient reports to this unit. The malaria/chloroquine use report goes to the National Malaria service. The family planning (presently, for one region, only) and the diarrheal disease reports go to the Division of Mothers and Children (DME).

At least for the immunization reports, the Statistics bureau can show that the reports arrive from the Médecin-chef in a timely manner. Within two months of the end of the reporting months, most médecin-chef's packets of prefecture reports are in the Statistics unit. We were unable to ascertain whether all the health facilities in a prefecture reported for every month. We were told this is the responsibility of the médecin-chef, but we found that most médecins-chefs had no system for routinely verifying the arrival of all reports.

In effect, the data at the national level remain scattered among the vertical programs. The fragmentation of information parallels the fragmentation of programs. At present, only those reports sent to the Statistics Bureau are routinely analyzed and published. They become the core of the Statistical Yearbook with supplementary information on personnel, budgets, and facilities obtained from the Administrative Division. Except for the Yearbook, health centers and médecins-chefs receive no feedback on the data that has taken up so much of their time.

Coordination among the different vertical programs and the statistical service seems weak and in one case we observed, non-existent. During our field visits, the DME official accompanying us discovered that a new integrated reporting form for prenatal/postnatal consultations, immunizations, and family planning had been distributed by the Statistics Service for immediate use by the prefecture. This form, which did not meet the needs of the DME programs, had never been reviewed by anyone in the DME including the Director. Nor had the Director-General been informed that new forms were being developed. The forms had been designed in the statistical services and printed with the assistance of WHO, but only the Epidemiology Division of which the statistical services are a part, was aware of this activity.

This fragmented information system cannot provide the data the Ministry needs for integrated planning and management at local, regional, and central levels. Not only is the quality of the data a problem, but the utility of some of it is also not clear. At present, aside from the Yearbook which presents data only on morbidity, hospitalizations, infrastructure, and global data on

budgets and personnel, none of the other data collected are readily available to the Ministry.

b. Periodic surveys:

The second source of data for the Ministry is periodic surveys and studies. Donors, particularly USAID, have financed numerous surveys, frequently using the URD (University Research group). The most extensive of these is the Demographic and Health Survey of 1988 which presents data on fertility, family planning knowledge and use, and some health practices. The URD has also studied maternal mortality using patient records of the university Health Center. The URD is planning to do a second DHS survey in 1993, if it can find funding.

c. Census :

The Census, which was last undertaken in 1981 (with aid from donors, principally UNFPA and USAID), provides the population denominators for calculating the incidence rates and effective coverage of Ministry programs. The Census was carried out by the Division of Statistics in the Ministry of Plan. Because of difficulties in processing, the final results were not available until several years later. The Ministry published a short analysis of interest to policy makers in 1989. The Ministry of Plan has also made available population estimates through 1995 on the basis of the 1981 census. The Ministry is currently making plans to conduct its next census at the end of 1991.

d. Quality of Data:

The quality of data from these sources varies considerably. It gives rise to a plethora of estimates reported in various documents and carried from one document to the next without a check on its validity.

Mortality data are hard to collect in a country where the vital statistics system is so imperfectly implemented. Infant mortality, that vital measure by which all countries are compared, has been estimated in two ways, with different results. The Census of 1981 included a question about deaths in the household. Many of the census takers forgot to ask this question so that when no deaths were listed, it meant either that there were none or the question had been skipped. After massaging the data, their re-estimation of infant mortality rate was 130 per 1000. It is hard to know how reliable this estimate is, given the amount of manipulation that was needed to arrive at it.

The second estimates of infant mortality came from the 1988 Demographic and Health Survey where mothers were asked to recall a ten year history of their children's births and deaths. Table 1 shows the results and demonstrates the differences obtained using

different methods. Surveys tend to underestimate deaths unless the sample is sufficiently large. The DHS sample size, although sufficiently large for most of the questions asked, is probably insufficient for a reliable estimate of infant mortality.

The maternal mortality estimate of 700 per 100,000 which was cited frequently, we were told, is the mean of two studies: a URD country-wide survey in 1985-86 produced a rate of 1000 per 100,000; and a study of mortality in Lomé in 1986 produced the rate of 420 per 100,000.

Since surveys are expensive and provide only periodic information, it might be useful to consider alternate ways to measure, at least, maternal deaths. At a minimum, routine reporting and analysis of maternal risks and maternal deaths at all health centers, should be considered. The obligation to maintain such records in good order would also be essential to help a facility manage its maternity services.

One final note about estimates from surveys. During our interviews, we became aware that many people in the health sector, Togolese and expatriates, were taking very seriously the point estimates from surveys and were using them to compare regions. Statisticians normally put confidence limits around their point estimates. For example, if the confidence limits of the DHS 1988 survey question on infant mortality is 10 percent, the true infant mortality rate for 1983-87 is not 81, but anywhere from 72.9 to 89.1. This kind of refinement is not important if all that is wanted is a general idea. But if policy makers are going to compare one year with the next, or one region with another, then they need to know that the estimates are ranges and that if the ranges overlap, the differences between them are not significant. These ranges should be reported rather than the point estimates.

Morbidity data from the health facilities' routine reports present problems of quality, which were discussed earlier. These problems emerge when one attempts to analyze the results of, for example, the Statistical Yearbook of 1989. They are also, of course, limited because they represent only those ill persons who happen to walk or get carried into health centers. It is like estimating the size of an iceberg from the tip. Nevertheless, such data systematically and routinely reported are useful for planning and managing health services, even though not necessarily epidemiologically valid on a population basis.

Management information data is in short supply in the current data system. Certain important management data are not now routinely collected, such as the stock of drugs, something that would help clinic managers plan their orders and assess utilization. Nor do the smaller hospitals have a form that could help them keep track of their daily census. The data already collected on epidemiological conditions and health services activities are not

then used to assist local managers to plan their services. What are needed are a series of indicators derived from these data to assist them to evaluate their activities.

One group of such indicators could be based on the population in a health center's catchment area in order to assess coverage. This would mean training health facility workers to be familiar with the population size of the surrounding area. With the availability of a new census after 1991, this should not be a difficult task. These indicators would include immunizations, child health visits, and prenatal visits and monitored births per target population. Other indicators include the completion rate of immunizations; the number of children receiving the third dose compared to those who received a first dose, which is a good measure of a health center's ability to follow-up its clientele. Médecins-chefs could use indicators to assess problems in clinic management, for example, clinic activity by the number of available personnel. The development of such indicators for local, regional, and central health personnel would provide not only information for management, but could also help health workers understand why the data they collect is important. This, in turn, could improve the quality of data collected.

As we noted earlier, the information system has improved considerably. This is due in no small part to the activities of the CCCD program which has installed computers in the Statistics bureau, provided training, and provided technical assistance. Credit also goes to the head of the Statistics bureau who has implemented these changes. He, however, is handicapped by the fact that he is the only one in his office at his level of training, and that despite the fact that they are coding medical diseases, they have, in the bureau, no personnel trained in health. More worrisome is that this indispensable bureau head is due to retire at the end of this year and so far, the Ministry has made no plans for his replacement.

The Statistical Yearbook represents the culmination of the work of the Bureau and as such, represents both the strengths and weaknesses of the existing system. Among the strengths are the fact that the Bureau has succeeded in publishing such a document for three years in a row in less than six months after the end of the last year. This is not an easy task. The 1988 version improved considerably over the 1987 one. The 1989 Yearbook may also represent an improvement but we were unable to judge since only the first volume, with epidemiological and global personnel and infrastructure data and a few draft tables from the second volume, are available as of this writing. The Yearbooks for the past two years have made good use of graphics for presenting trends in diseases.

We noted, also, important weaknesses in the way data are analyzed and presented. For example, the new relevé should produce a list

of 50 diseases, which should permit policy makers to analyze the most important health problems in the country. However, nurses were allowed to write in additional ones. The Yearbook publishes this compilation of the original 50 plus a dubious collection of some nearly 200 creative diagnoses written in, all of which should have been categorized under the original disease classifications. This method of reporting makes a mockery of attempts at standardization of disease classification.

Analysis of disease data for children are also difficult because the data are reported not only by age group, but also by sex. Thus to know the number of children under one year who have had measles, you have first to add the boys and girls together. Such presentation does not make it easy for policy makers, who are not trained as statisticians are, to make calculations. Moreover, for children, at least, it is not evident why you need disease information by sex. The added columns and rows engender greater errors, lower compliance, and ultimately no information that will be used routinely for planning and/or management.

The data presented could also benefit from more editing to avoid obvious errors such as identifying two girls under five years old as having consulted for prolonged pregnancies. The tables of immunization coverage emerged with some anomalous results indicating that in some areas more than 100 percent of children in the area had received, for example, BCG vaccine. Whether this results from underestimates of the population or re-immunization of the same children, or both, it suggests both the need to improve the reporting and the need to use the data to supervise activities on the ground.

e. Issues in information system development:

The improvements in the management system have been significant. They can form the base for the Ministry's development of an effective management information system. However, much work needs to be done to overcome the verticality of the present system, the duplication of reports, and to build an integrated system that can serve the management needs of the Ministry at all levels. What happens now is that each program thinks small, about its own needs. Moreover, programs tend to get competitive with each other, fearing perhaps that if others get control, they will never have the data they need. This competitive approach merely complicates the task of the health worker at the bottom of the chain who has to integrate these warring programs.

One could forgive the verticality if, at least, the information system provided reliable routine data for local and central policy makers in a timely manner and in a usable form. In our experience, little of such quality is available. Basic information on the health infrastructure, such as a list of all health facilities in Togo, proved difficult to locate. The Ministry has no central

source of these data. Those in need of information go from one office to the next. We were frequently told that some other office might have what we were looking for. The only information available in a central document is the Statistical Yearbook. Even that has limitations as the data are presented in ways that make it difficult to interpret them. The recent experience of the Ministry in its analysis for the World Bank project demonstrates the difficulty that it has in mobilizing data adequate for planning. We were told of the difficulties experienced by those preparing the documents in finding consistent and reliable data in a form which they could use.

Why does the information system function the way it does and what can be done to improve it? The reasons it functions as it does are as follows:

- Program verticality reinforce information verticality.
- Centralization plays a role, as each program tries to consolidate control over its program by monopolizing data.
- Current system is not geared to the skills of those creating and using it. The demands it puts on health worker in diagnostic acumen and arithmetic skill are extremely high, particularly when one considers that the main purpose of their activity is to care for patients, not fill out forms.
- System is not geared to the meeting the management needs of local, regional, and central policy makers. If the data he painstakingly gathered actually would help him manage his clinic, a health worker would have greater incentive to collect and report it correctly. If the data collected were relevant to the mèdecins-chefs management needs (and if he had some autonomy in planning), he would have an incentive to supervise more carefully and to allocate resources more thoughtfully.

An information system can serve as a powerful tool for integrating health service activities. This integration, however, can be achieved only through the building up of a consensus within the Ministry on what the information needs are and how they are best met. It involves negotiation and selection in a process oriented toward reducing and simplifying reporting. To reach such a consensus is a lengthy process. No information system can meet all the needs of every program. In order to provide integrated services, each program will have to give up something. In the process of forging compromises, program directors will be forced to sit down face-to-face to create an integrated information system. This process, in itself, can help create the integration needed among the vertical programs.

5. Summary of Constraints and limitations:

As we have seen, the Ministry of Public Health faces a number of organizational problems which have arisen from the historical effects of centralized administration, verticalization of programs in response to internal and external pressures, and an information system which compounds these problems rather than helps policy makers find solutions. Local health managers need assistance in carrying out their supervisory functions, while community-based health care is not tied to the health system. There are also capable personnel at all levels of the Ministry and an awareness that they need to start working to integrate their hitherto disparate activities.

C. Plans for Reorganization of the Ministry of Public Health

As part of the process of developing the Health and Population Sector Loan with the World Bank, the Ministry of Public Health and the World Bank missions in December 1989 (Pre-Evaluation) and in April-May 1990 (Evaluation) have prepared a series of reorganization plans. This has been an iterative process in which different options were suggested and commented on by both sides in the negotiation process.

After the November mission, the Ministry of Health engaged in an intense and detailed effort to prepare a reorganization plan to present to the April mission. The preparation effort involved almost all Ministry divisions and services, as well as the University and the CHU. The Ministry of Plan was partially involved, but not as much as it had been in the November mission. Individuals from the UPC were also involved but did not play as central a role as one might expect from a planning unit.

As we noted above, most observers of the Ministry -- both internal and external -- have found that the Ministry suffers from two major organizational pathologies: too much centralization at the highest administrative levels and too much fragmentation of programs into vertical projects which do not coordinate well with each other. The reorganization plan presented by the Ministry responded to the World Bank's requirement that reorganization address these two problems. The proposed reorganization reduced the Ministry Directorates from eight to three, and provided a more rational basis for integrating programs. It also prepared detailed task descriptions for each Directorate, Division and Service, and qualification requirements for their chiefs. During the April mission, negotiations continued with the Bank revising the plan so that five Directorates would be created.

At the end of the April mission, the World Bank team left an Aide-Memoire describing the mission's understanding of the reorganization plan. Figure 4 shows the latest reorganization proposal. This proposal is expected to be the subject of final

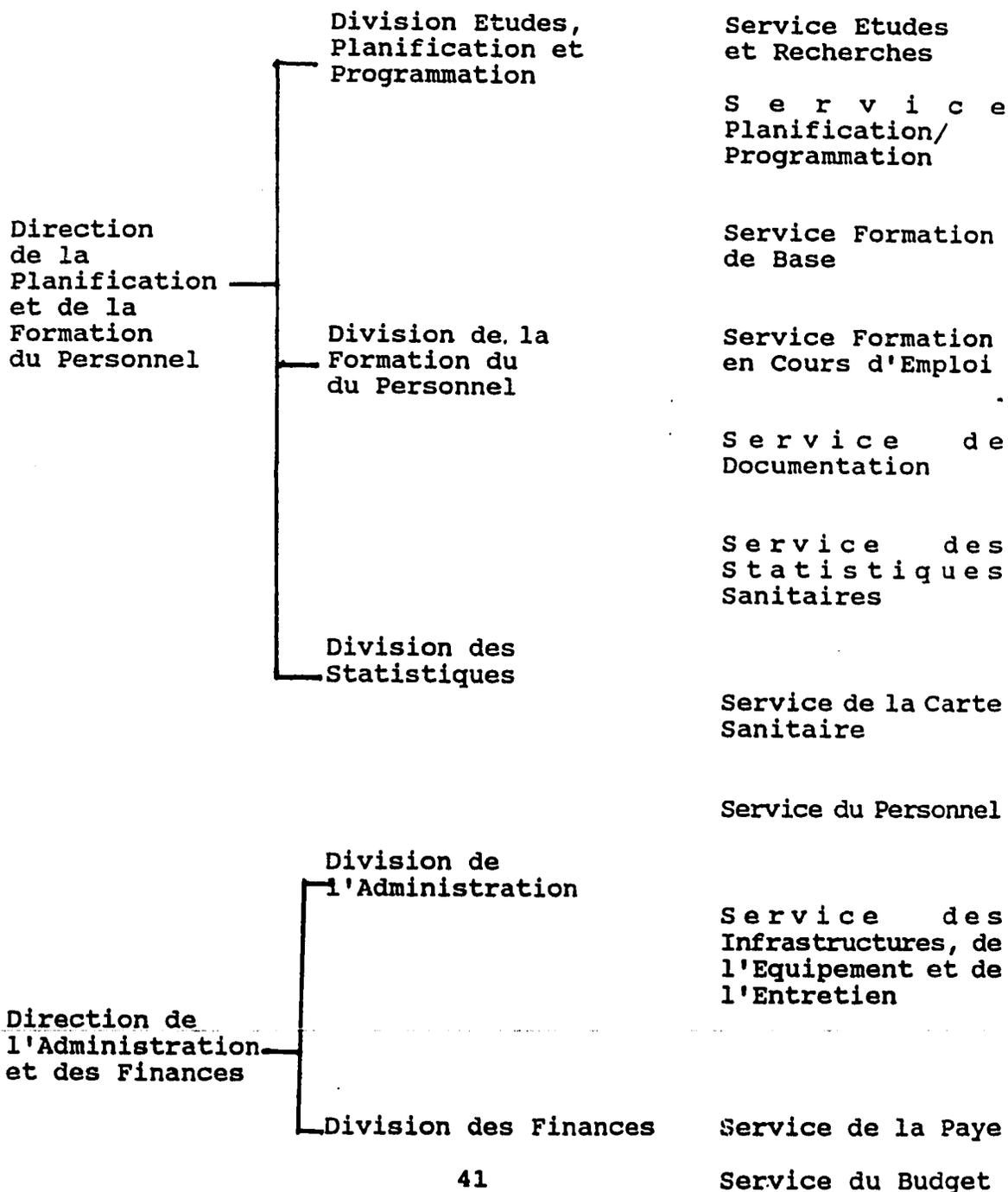
Figure 4

PROPOSITION DE RESTRUCTURATION ORGANIQUE
DU MINISTERE DE LA SANTE PUBLIQUE

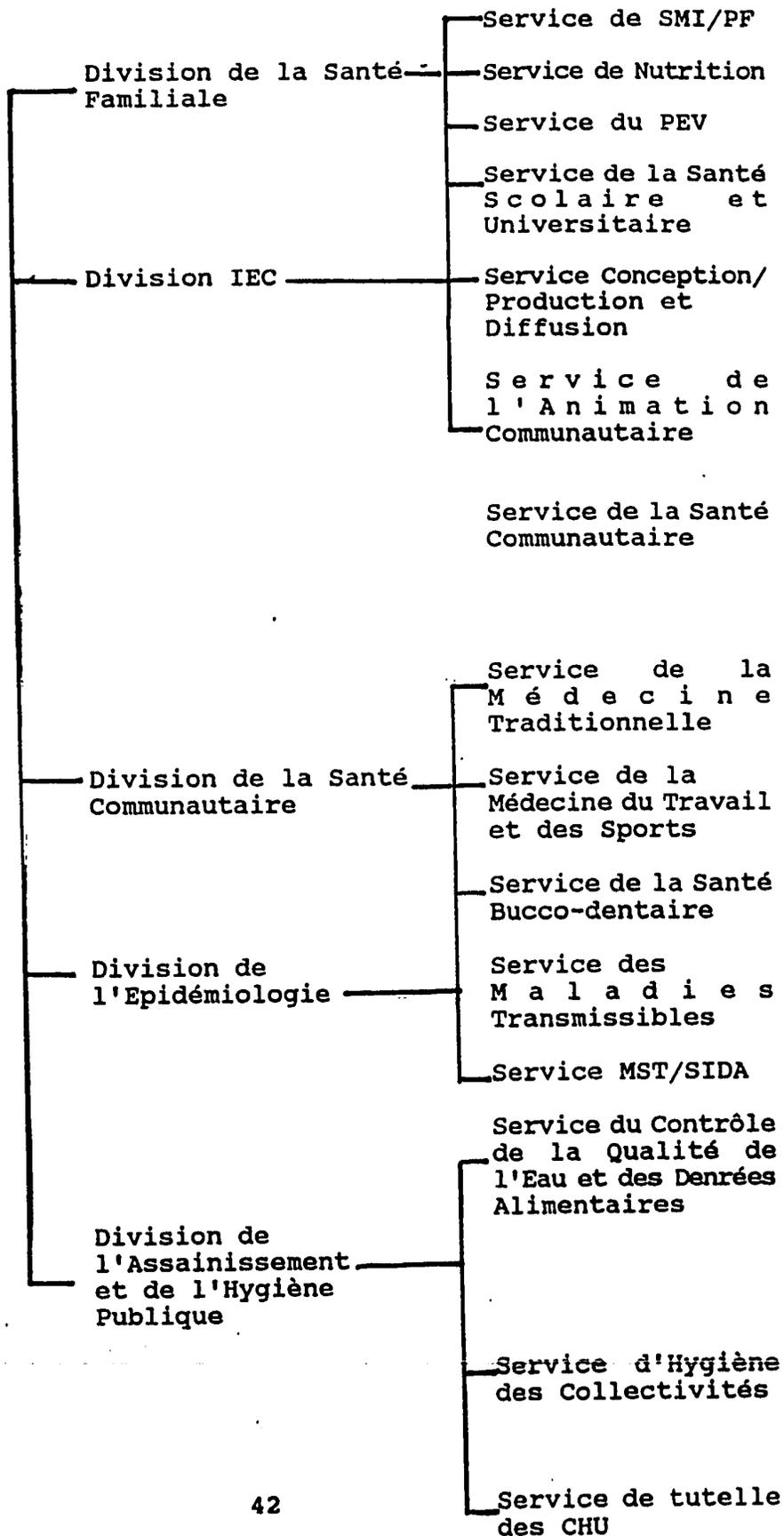
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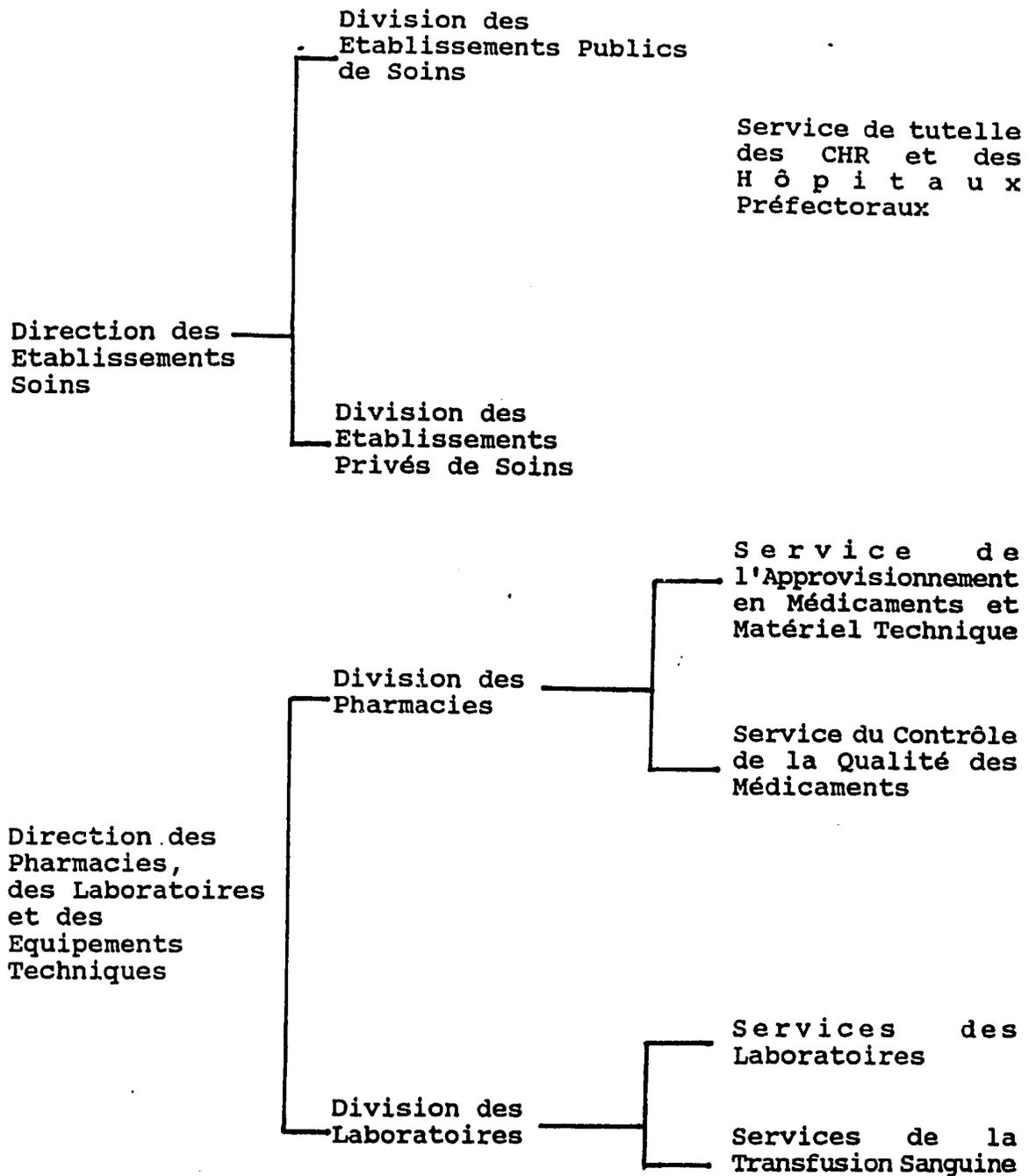
DIRECTION GENERALE DE LA SANTE

Unité de
Législation
Sanitaire



Direction des
Soins de Santé
Primaires





negotiations during the Project Pre-Appraisal mission, scheduled for July.

There is some doubt that the government will achieve the pre-conditions that have been set for the Pre-Appraisal mission, and the reorganization plan is open to renegotiation in any case. Nevertheless, the reorganization as presented in the Aide-Memoire, appears to have the general consensus of most of the Ministry -- with some notable exceptions, which we will discuss below.

The reorganization plan has several elements that we think could go a long way toward overcoming major organizational problems of the Ministry.

First, the plan is logical in its organization of the five directorates, and its reorganization of the services. This organization will assist the integration of priority programs in maternal and child health. It makes sense to place all the operational and support activities under the Director General, who can now take central responsibility for coordinating all activities under the strategic guidance of the Minister's Cabinet. The Directorate of Planning and Training will unite several support activities that are essential for all the other operational directorates: 1) planning, programming and research; 2) statistics; 3) pre-service and inservice training. The Directorate of Primary Health Care will unite all primary health activities and will be separate from the Directorate of Medical Establishments -- the hospital sector.

The Directorate of Primary Health Care will have several important Divisions which are logically organized for priority programs. The most important improvement is the placement of all maternal and child health activities in the Division of Family Health. This division will unite the following services: a) Maternal and Child Health and Family Planning, b) Nutrition, c) PEV, d) School and University Health. Although it does not appear in the chart (probably from oversight) the original discussion documents have placed the diarrhea control program also in this Division. If this organization is implemented, all of the Child Survival and Family Planning activities except malaria will be formally integrated into one Division.

The other two directorates -- Water and Sanitation, and Laboratories and Pharmacy, are also sound means of administering these activities.

There is some discussion now that suggests that several of the proposed changes will be resisted and alternatives proposed during the final negotiations with the Bank. It is not clear that the PEV, now a central and effective program with considerable donor support and with an energetic leadership, will move gracefully from the Division of Epidemiology to the Division of Family Health. As

one of the major donors in this area USAID might play a role in this debate. As will be clear in the recommendations at the end of this report, we feel that the reorganization plan of the Aide-Memoire, that places PEV where it can more easily be integrated into the other Child Survival programs, is an essential requirement for improved health services.

The other issue being discussed now, is the addition of responsibility for donor coordination to the Division of Planning, Programming, and Research. This additional role, would be an important improvement in the Aide-Memoire reorganization scheme.

Finally, it is not clear from the Aide-Memoire whether the National Health Education Service (SNES) will continue to function as a separate entity. None of the task descriptions show an emphasis on health education. We feel that health education should be a priority and should be integrated into all programs of child survival and family planning. A separate health education service should be continued and upgraded to give this essential support activity the appropriate emphasis in all programs. Without a separate unit, health education tends to be downgraded and the appropriate skills remain undeveloped. It would make sense to keep the SNES as a separate service under the Division of Training.

In summary, the proposed reorganization plan, as presented in the Aide-Memoire, would be a significant improvement in the integration of important programs. We have oriented our recommendations so that USAID can provide support for this process and assist in its implementation. Nevertheless, since the final reorganization plan is not yet established, our proposals do not depend on the current plan.

The other objective that is presented in the Aide-Memoire, encourages greater decentralization of the Ministry. Unlike the design of a reorganized central Ministry, the proposals for decentralization are not well articulated. Their broad outlines suggests transfer of authority for budgetary, programmatic and personnel decisions to regional and prefect levels. The Aide-Memoire focuses attention on the implementation of Regional offices, which had been legally established as early as the 1969 reorganizations, but had not been implemented. As noted in our recommendations [Section IV.A.2], we believe a regional office will not contribute much to the process of decentralization, and that the prefecture (subdivision) should be the major focus of activity and support. The reorganization plan encourages decentralization to this level. It also includes proposed legal structures necessary for the establishment of juridical entities in health facilities which would permit them to manage funds and activities through an elected management board.

As noted above in the section on management information, the World Bank Aide-Memoire also places emphasis on the importance of

developing an effective management information system as part of a process of administrative strengthening and reorganization. [Section II.B] In our recommendations, we discuss how USAID's contribution in this area could complement and reinforce this aspect of the World Bank proposals.

The reorganization also anticipates significant changes in financing -- increasing the national budgetary resources devoted to the health sector, and allowing for major efforts in cost-recovery. We discuss these aspects in the following Section [III].

III. FINANCING AND SUSTAINABILITY

A. Introduction

Since independence in 1960, the Government has been committed to providing free health care to the population which in turn regards publicly provided health care as a citizen's right.

Currently the Government remains the largest source of financing of health care in the country. However, there are also important contributions from donors, non-government organizations (NGOs), households and the private sector. While the Government and households finance most of the recurrent expenditures, donors play a major role in financing investment expenditures.

Over the past few years, macroeconomic difficulties have seriously affected the government's ability to devote adequate resources to the health sector. Accumulating budget deficits and worrisome and fast growing external debt have led the Government to adopt the IMF and the World Bank-supported Financial Stabilization and Structural Adjustment Programs which, among other measures, require the Government to reduce spending. Although the share of health in overall government expenditures has not changed much as a result of the fiscal restraint, real per capita recurrent expenditures have fallen by 23% between 1978 and 1987. It is, therefore, increasingly felt that alternative sources of financing should be found to supplement the Government resources.

To help the Government develop and implement certain basic health programs and meet the increasing demand for health care, several donors and NGOs have intensified their assistance to the country through the financing and/or the implementation of several primary health projects or programs.

However, this assistance does not resolve the financing issue entirely. It has become clear that the current financial situation cannot allow the government to improve the deteriorating situation in public health facilities and to meet the fast increasing demand. In addition, the sustainability of most donor-supported projects has become a major issue. Donors are increasingly concerned about the future of their projects after their funding stops. Many donors such as GTZ, CUSO, and recently, UNICEF through the Bamako Initiative, and the World Bank in the Health and Population project, include cost recovery mechanisms in their project agreements. They also advise the government to develop and implement cost recovery programs in public facilities. Recently, some donors have even included cost recovery among their conditions precedent. As a consequence, and despite its earlier reluctance, the government is making increased effort to develop a cost recovery system to suit the current resource needs.

B. The Government's Financing of Health Care

Health represents about 5% of overall Government expenditures. See Table F-1. Government health expenditures are financed through the Ministry of Public Health and the University Teaching Hospitals (CHU) budgets. These budgets have two components: the recurrent budgets controlled by the Ministry of Finance and the investment budgets controlled by the Ministry of Planning. The Ministry of Health executes its budget mainly through the Service des Affaires Administratives et Financières at the central level, and the Médecins Chefs de Subdivision at the level of the Subdivisions Sanitaires. Financially, the CHUs are entirely independent of the Ministry of Health; therefore, the execution of their budget does not involve the Ministry of Public Health directly.

Table F-1

HEALTH RELATED EXPENDITURES AS PERCENTAGES OF OVERALL RECURRENT

	MOH (1)	AS & CF (2)	MOH + AS & CF (3)	Overall GOT Budget (4)	(1)/(4) %	(2)/(4) %	(3)/(4) %
	F mil.	F mil.	F mil.	F mil.			
1975	1252.2	189	1441.2	30514.7	4.1	0.6	4.7
1976	1584.5	261.9	1846.4	35768.9	4.4	0.7	5.2
1977	1770.2	274.6	2044.8	39850.8	4.4	0.7	5.1
1978	2578.0	333.1	2911.1	45034.6	5.7	0.7	6.5
1979	2496.0	350.7	2846.7	52142.2	4.8	0.7	5.5
1980	2837.9	402.8	3240.7	59873.2	4.7	0.7	5.4
1981	2724.1	364.7	3088.8	66665.7	4.1	0.5	4.6
1982	3488.1	480.5	3968.6	72037.0	4.8	0.7	5.5
1983	3403.3	468.2	3871.5	71979.8	4.7	0.7	5.4
1984	3347.1	490.9	3838.0	73263.2	4.6	0.7	5.2
1985	3477.8	459.5	3937.3	78290.0	4.4	0.6	5.0
1986	3500.0	474.2	3974.2	82282.8	4.3	0.6	4.8
1987	3485.6	455.4	3941.0	89691.5	3.9	0.5	4.4
1988	4204.7	553.5	4758.2	86392.1	4.9	0.6	5.5
1989	4573.4	553.1	5126.5	89026.9	5.1	0.6	5.8
1990							

Source: MOH.

1. The Financial System of The Ministry of Health

The Ministry of Public Health's financing mechanisms are "decentralized" to the prefecture (Subdivision Sanitaire) level. The execution of the Ministry of Public Health budget is essentially assured at this level by the Médecin Chef de Subdivision. Each Subdivision Sanitaire is allocated a budget from the central level. However, the Subdivision's recurrent budget has rigidly defined rubrics; funds cannot be transferred from relatively over-funded or less active rubrics to relatively under-funded or more active ones. If a line item is not used up, it has to be returned to the Treasury. Similarly, all revenues made at public facilities are automatically and directly transferred to the Treasury which solely has the authority to decide on how to use them.

Although the Médecin Chef de Subdivision is given some flexibility regarding the use of the funding allocated to rubrics, the rule that resources cannot be shifted between rubrics reduces the efficiency of the system.

The Prefets -- each Subdivision Sanitaire corresponds geographically to a Prefecture -- are responsible for the audits and budget control in the Subdivisions Sanitaires. This type of decentralization to the prefectorial level is hardly a decentralization since the Prefet is nothing but the representative of the central government at the district level and acts only as an auditor. No similar control system exists at the central Ministry of Public Health level.

2. The Financing System of The CHUs

The CHUs have financial autonomy and get their budgets directly from the Ministry of Finance which controls the execution of this budget. In 1990, the two CHUs' budget amounted to CFA 2.4 billion, more than one third of total Ministry of Public Health budget.

As in the case of any other public health facility, all revenues made at the CHUs are transferred to the Treasury.

3. The Ministry of Public Health Expenditures

a. The Structure of Ministry of Public Health Expenditures

As Table F-2 shows, recurrent expenditures represent 84-95% of total Ministry of Public Health expenditures. Recurrent expenditures are mostly financed by the government while donors play a major role in the financing of investment expenditures. Depending on the years, 28 to 72% of total investment expenditures

are financed by donors. See Tables F-6 and F-7. It should be noted however, that there has been a blurring of the distinction between recurrent and investment budgets in recent years. Anecdotal evidence suggests that project salaries are being paid out of investment budgets even if the activity would be considered a recurrent cost under previous definitions. Table F-2 shows an increase in investment budget as percentage of total health budget beginning in 1987, which may reflect this shift toward inclusion of recurrent costs.

Table F-2

GOVERNMENT HEALTH EXPENDITURES BY THE TWO MAJOR FUNCTIONAL CATE

	Recurrnt Health (1)	Investmnt Health (2)	Total Health (3)	Tot. GOT Investmnt (4)	(1)/(3)	(2)/(3)	(2)/(4)
	F mil.	F mil.	F mil.	F mil.	%	%	%
1975	1252.2						
1976	1584.5						
1977	1770.2						
1978	2578.0						
1979	2496.0						
1980	2837.9						
1981	2724.1						
1982	3488.1						
1983	3403.3						
1984	3347.1						
1985	3477.8	198.1	3675.9	4439.4	94.6	5.4	4.5
1986	3500.0	216.6	3716.6	6314.1	94.2	5.8	3.4
1987	3485.6	655.3	4140.9	14327.4	84.2	15.8	4.6
1988	4204.7	366.5	4571.2	8816.5	92.0	8.0	4.2
1989	4573.4	622.3	5195.7	10786.0	88.0	12.0	5.8
1990							

Source: MOH.

b. Trends in Ministry of Public Health Recurrent Expenditures

Although investment expenditures show an upward trend in the second half of the 1980s, overall Ministry of Public Health expenditures have fallen significantly in real per capita terms over the last decade. In particular, as Table F-3 shows, real per capita recurrent expenditures have fallen by 23.1% between 1978 and 1987. The downward trend in the Ministry of Public Health recurrent expenditures is expected to continue at least through the early

1990s according the 1990 budget and the budget projections for the following years. Clearly, the Government's ability to satisfy the increasing demand for health and to upgrade the service in public health facilities is hurt and this situation needs to be corrected.

Table F-3

GOVERNMENT RECURRENT HEALTH EXPENDITURES

	Popoul.	Nominal Expend.	Nominal per Cap. Expend.	CPI	Real Expend.	Real per Capita Expend.	Growth Rate of per Cap. Expend
	'000	F mil.		1970=100	F mil.	F	%
1975	2198.7	1252.2	569.5	158.3	791.0	359.8	
1976	2255.6	1584.5	702.5	176.6	897.2	397.8	10.6
1977	2312.1	1770.2	765.6	216.3	818.4	354.0	-11.0
1978	2371.1	2578.0	1087.3	217.3	1186.4	500.3	41.4
1979	2436.4	2496.0	1024.5	233.6	1068.5	438.6	-12.4
1980	2498.9	2837.9	1135.7	262.5	1081.1	432.6	-1.4
1981	2729.5	2724.1	998.0	314.2	867.0	317.6	-26.6
1982	2809.8	3488.1	1241.4	349.1	999.2	355.6	12.0
1983	2892.5	3403.3	1176.6	382.9	888.8	307.3	-13.6
1984	2977.6	3347.1	1124.1	368.8	907.6	304.8	-0.8
1985	3065.2	3477.8	1134.6	361.8	961.2	313.6	2.9
1986	3155.4	3500.0	1109.2	376.7	929.1	294.5	-6.1
1987	3248.3	3485.6	1073.1	376.9	924.8	284.7	-3.3
1988	3343.9	4204.7	1257.4				
1989	3442.3	4573.4	1328.6				

Sources: MOH; BCEAO for CPI.

The downward trends in the recurrent expenditures are not particular to the health sector, since the share of health in overall Government expenditures have not changed much. The declining health expenditures are simply the result of a general process of spending reduction imposed on the Government by the Financial Stabilization and Structural Adjustment Programs it has adopted since 1982 in order to improve its overall financial situation. In fact, it is interesting to see that in Togo these programs have not led to a clear transfer of resources from the health and other social sectors to the so-called growth generating and foreign exchange earning sectors, as they have in other countries. More interesting still is the help the health sector is expected to get from (a) the Fourth Structural Adjustment Program which is being prepared and which is supposed to give more

importance the social sectors, and (b) the World Bank-supported Health and Population Sectoral Project, also being prepared, a project which requires the Government to progressively increase its health expenditures by 6-8% per annum between 1991 and 1994.

One should note, however, that the approved 1991 health budget does not reflect this recommendation since it shows a zero nominal growth rate from the preceding year. In addition, even if the Ministry of Public Health real budget were to increase by 8% a year, it would take all five years of the project just for it to reach its 1978 per capita level.

c. The Structure of Ministry of Public Health Expenditures by Personnel and Non-Personnel Categories

Personnel costs represent 70-82% of total Ministry of Public Health recurrent expenditures. More worrisome is the fact that this share has followed an upward trend between the late 1970s and the late 1980 despite the government's effort to reduce personnel costs in the public sector since 1980. Table F-4 below describes the evolution of these categories of the Ministry of Public Health recurrent expenditures since the mid-1975.

Table F-4

MOH RECURRENT EXPENDITURES BY PERSONNEL AND NON-PERSONNEL CATE

	Personnel (1)	Non-Per- sonnel (2)	Total (3)	Ratios		Growth Rates	
				(1)/(3)	(2)/(3)	(1)	(2)
	F mil.	F mil.	F mil.	%	%	%	%
1975	960.0	292.2	1252.2	76.7	23.3	-	-
1976	1184.6	399.9	1584.5	74.8	25.2	23.4	36.9
1977	1349.8	420.4	1770.2	76.3	23.7	13.9	5.1
1978	1780.5	797.5	2578.0	69.1	30.9	31.9	89.7
1979	1762.3	733.7	2496.0	70.6	29.4	-1.0	-8.0
1980	2015.9	822.0	2837.9	71.0	29.0	14.4	12.0
1981	2053.6	670.5	2724.1	75.4	24.6	1.9	-18.4
1982	2653.5	834.6	3488.1	76.1	23.9	29.2	24.5
1983	2630.8	772.5	3403.3	77.3	22.7	-0.9	-7.4
1984	2698.1	649.0	3347.1	80.6	19.4	2.6	-16.0
1985	2834.5	643.3	3477.8	81.5	18.5	5.1	-0.9
1986	2864.3	635.7	3500.0	81.8	18.2	1.1	-1.2
1987	2796.4	689.2	3485.6	80.2	19.8	-2.4	8.4
1988	3338.1	866.6	4204.7	79.4	20.6	19.4	25.7
1989	3435.2	1138.2	4573.4	75.1	24.9	2.9	31.3

Source: MOH.

Non-personnel expenditures are more severely affected by the overall decline in Ministry of Public Health budgets than were personnel expenditures: real per capita non-personnel expenditures fell by 65.5% between 1978 and 1986 before starting an upward trend in 1987.

The small and declining share of non-personnel expenditures in the recurrent budget reflects to a certain extent the generally deteriorating situation in the public health facilities. In particular, in 1989, drugs, vaccines and other pharmaceuticals represented about 11% of total Ministry of Public Health recurrent expenditures.

d. The Structure of Ministry of Public Health Recurrent Expenditures by Level of Care

No adequate information exists on how Ministry of Public Health recurrent expenditures are distributed between primary care and hospital programs or other higher levels of care. The Central Level only decides on the budget allocations to the Subdivisions Sanitaires which in turn decide on how much to allocate to the different levels of care. Interestingly, the Central Level makes no effort to know how these allocations are made at the local level.

Only the budgets of the Centres Hospitaliers Regionaux (CHR) are known; those of the four Hopitaux de Plein Emploi and the thirteen Hopitaux de Subdivision are included in the overall budgets of the Subdivisions. In 1990, the combined budget of the two CHUs amounted to CFA F 2.4 billion, which was equivalent to 40% of the Ministry of Public Health expenditures. Likewise, the three CHR were allocated 51% of their respective regions' health budget; a big chunk of the remaining 49% is taken by the Hopitaux de Plein Emploi and the Hopitaux de Prefecture, which means that only a very small portion of the Ministry of Public Health budget goes to the financing of primary health programs.

With an improved management information system which includes financial data, it is possible, to have more detailed information at the local levels. It is also desirable that the Central Level start gathering detailed information on the distribution of the Subdivisions' expenditures and activities between the different levels of care. Hopefully, the restructuring of the Ministry proposed by the World Bank will make this effort easier.

In the case of investment expenditures, there exists some fairly detailed information about the allocation of funding between the major health programs. This information is summarized in Table F-5. This analysis clearly show that the major hospitals absorb much of the investment budget.

Table F-5

MOH INVESTMENT EXPENDITURES BY TYPE OF HEALTH PROGRAM OR ACTIVITY

	1985	1986	1987	1988	1989
CHU & CHRs (1)	80.2	67.7	41.8	59.9	234.6
Hop. Plein Empl (2)	16.9	24.7	8.2	19.9	28.9
HC&matrn (3)	18.7	27.7	58.9	59.5	80.0
Dispens. (4)	38.3	59.2	63.7	49.2	88.6
Hlth Programs (5)	44.0	38.9	31.3	69.3	84.6
Support to H Sect (6)	0.0	0.0	38.7	59.2	105.6
CNSS (7)	0.0	0.0	409.6	49.5	0.0
Total (8)	198.1	218.2	652.2	366.5	622.3
(1)/(8)	40.5	31.0	6.4	16.3	37.7
(2)/(8)	8.5	11.3	1.3	5.4	4.6
(3)/(8)	9.4	12.7	9.0	16.2	12.9
(4)/(8)	19.3	27.1	9.8	13.4	14.2
(5)/(8)	22.2	17.8	4.8	18.9	13.6
(6)/(8)	0.0	0.0	5.9	16.2	17.0
(7)/(8)	0.0	0.0	62.8	13.5	0.0
((1)+(2))/(8)	49.0	42.3	7.7	21.8	42.3

C. Mobilizing Other Sources of Funding

The Government's budget is not the only source of financing for health expenditures. The other major sources of funding are:

- donors;
- NGOs; and
- households.

Other sources include private insurance systems, which are not well developed yet, and the Government-funded social security system which is managed by the Caisse Nationale de Securite Sociale (CNSS). The CNSS is a social insurance system for workers and their families.

1. Donors

In general donors finance investment and technical assistance expenditures through the funding and/or the implementation of various projects. They put relatively little emphasis on recurrent expenditures. In particular, the German Cooperation, through GTZ, has made it clear to the Government that it does not finance recurrent expenditures.

In 1988, donor contributions amounted to over CFA F 1.3 billion which was equivalent to 26% of total Ministry of Public Health expenditures. In 1989, donor financing was intensified especially with the strengthening of certain programs such as the AIDS control program: donor aid was estimated at CFA F 5 billion, which was equivalent to 96% percent of total Ministry of Public Health budget. This represents a very high dependence ratio and has some important implications for the sustainability of most of the donor-supported projects. Indeed, the high dependence ratio implies that it may be hard for the country to find the necessary resources to finance the recurrent costs of these projects if donor funding declines or stops.

The fact that the dependence ratio seems to be increasing should be viewed as a major concern given the current macroeconomic context of the country and given the difficulty the Government seems to be having developing alternative financing systems.[see below]

Table F-6 below describes total donor contribution to the financing of health care over the past two years. Table F-7 describes the donor contribution to the financing of investment expenditures over the past five years.

Table F-6

DONOR CONTRIBUTION TO THE FINANCING OF HEALTH CARE IN TOGO
in millions of CFA francs

	USAID	GTZ	CUSO	FAC	FSD	UNICEF	WHO
1988	810.0	226.7	107.5	--	229.5	211.2	360
1988	1660.2	1261.7	71.6	200.0	--	353.8	1452.0

Sources: Ministry of Public Health; USAID

Table F-7

CONTRIBUTION OF MAJOR DONORS TO THE FINANCING INVESTMENT EXPEND

millions of francs

A: BILATERAL DONORS

		1985	1986	1987	1988	1989
USAID	Soc&Hlth	0.0	13.6	165.9	0.0	0.0
	CS				56.0	56.0
	Total	0.0	13.6	165.9	56.0	56.0
CUSO						
FRG/GTZ	HC&Matrn	0.0	147.6	31.6	28.3	0.0
FAC	Hospitals	0.0	0.0	0.0	0.0	0.0
	HS&Matrn	0.0	1.1	0.8	0.0	0.0
	Support to H sect	0.0	0.0	0.0	0.0	42.6
	total	0.0	1.1	0.8	0.0	42.6
FSD	HC&Matrn	0.0	0.0	0.0	134.2	76.9
Other						
Total						
Bil. Don. (1)		0.0	162.3	198.3	218.5	175.5

TABLE 7 - (Con't)

B: MULTILATERAL DONORS

		1985	1986	1987	1988	1989
ADB	Hospitals	507.0	264.0	0.0	0.0	0.0
	Hospitals	0.0	0.0	70.3	85.3	27.3
FED	Dispens.	11.5	7.4	1.7	22.2	22.8
	Total	11.5	7.4	72.0	107.5	50.1
IDA	Support to H Sect	0.0	0.0	0.0	38.0	16.5
Total Multil. Don. (2)		518.5	271.4	72.0	145.5	66.6
Total Donors (3)		518.5	433.7	270.3	364.0	242.1
Total GOT (4)		198.1	216.6	655.3	366.5	622.3
TOTAL (5)		716.6	650.3	925.6	730.5	864.4
		Percent				
(1)/(5)		0.0	25.0	21.4	29.9	20.3
(2)/(5)		72.4	41.7	7.8	19.9	7.7
(3)/(5)		72.4	66.7	29.2	49.8	28.0
(4)/(5)		27.6	33.3	70.8	50.2	72.0

Source: Ministry of Planning.

Both bilateral and multilateral donors are active in the financing of health care in Togo.

a. Bilateral Donors

The most important bilateral donors are:

- USAID;
- GTZ;
- CUSO; and
- FAC.

(1) USAID

USAID is generally the largest bilateral donor in the area of health. USAID's assistance comes mainly through three projects, the CCCD project, the Health Sector Support for Child Survival project and the Family Health Initiative II Project. Table F-8 summarizes these projects and their budgets. USAID also intervenes indirectly through some US Government-supported organizations such as the Peace Corps and through support to some NGOs such as Catholic Relief Services (CRS/Cathwel).

In 1989, total USAID contribution for the health sector in Togo was estimated at CFA F 1.7 billion, which was one third of total donor contribution, and the largest of all donors, bilateral and multilateral. This level of financial dependence on one donor raises serious questions about sustainability of USAID projects. (see below)

TABLE F-8
USAID'S CONTRIBUTION TO THE FINANCING OF HEALTH
\$ '000

	1988	1989	1990	1991
HSSCS	110	1004	1500	1886
CCCD	202	148	422	788
FHI-2	169	533	301	497
PL-480 (CRS)	2219	4059	3313	3592
TOTAL	2700	5744	5536	6763

Source: USAID

(2) GTZ

In 1989, with a contribution of CFA F 1.3 billions, GTZ was the second largest bilateral donor, and third overall. Currently GTZ operates in the country through five projects:

- the Maternité de Bé project;
- the Primary Health Care Project in the Central Region;
- The CHU Technical Assistance Project;
- The AIDS Control Project; and
- The Health and Population Project also financed by the World Bank.

Table F-9 below summarizes GTZ's current projects and their budgets.

TABLE F-9
THE GERMAN COOPERATION (GTZ) 1987-1994
in millions of Deutsche Marks

	Maternite Bé	TA at CHU	PHC Cntrl R	AIDS Control	H&Pop w/IDA	TOTAL
PERIOD	87-92	87-90	88-94	89-91	92-94	87-94
1987	0.8	0.1				0.9
1988	1	0.2	0.2			1.4
1989	1	0.2	0.9	0.2		2.3
1990	1	0.1	0.9	0.4		2.4
1991	1		0.9	0.2		2.1
1992	1		1		1.8	3.8
1993			1		1.8	2.8
1994			0.8		1.8	2.6
PROJECT						
TOTAL	4.8	0.5	5.7	0.8	5.5	17.3

Source: GTZ

(3) CUSO

CUSO operates mainly through its Water Project, the Projet d'Hydraulique Villageoise, in two Prefectures of the Region Maritime, Yoto and Zio. CUSO also participates in EPI activities in the whole Maritime Region where it does training, IEC and provides three cars and ten motorcycles.

(4) FAC

The French Cooperation participates in EPI support activities (motorcycles), provides scholarships for training of physicians and other skilled health personnel in France, and gives technical assistance to hospitals.

b. Multilateral Donors

There are five main multilateral donors in Togo:

- WHO;
- UNICEF;
- UNFPA;
- The World Bank through its Health and Population Project. It is a \$30 million project to cover a five year period starting in 1990. The World Bank is contributing \$14 million and the Federal Republic of Germany, about \$4 million. The rest of the funding would be provided by the Government and other sources;
- FED through three main projects:
 - the family planning project with 176,000 ECUs for 1988-93,
 - the primary health infrastructure project in Bassar, with 170,000 ECUs for 1990-94, and
 - the AIDS control program with a budget of 468,783 ECUs for the 1990-92 period.

3. NGO'S

There are a lot of NGOs involved in the health sector in Togo, however comparable financing data for NGOs is generally unavailable. (see Evlo, 1989, Inventory)

4. Household and the Private Sector

a. Private Sector Provision of Health Care

There is a relatively important private sector in Lomé represented by private clinics and health centers. There are also three private hospitals run by different religious organizations:

- the Catholic Church at Afagnan;
- the Protestant Church at Agou;
- the Baptist Church at Kpele Tchiko.

However, the magnitude of the private sector activities is not known.

b. Households and the Financing of Health Care.

Despite the general belief that health services should be provided free of charge to the population by the Government, households and individuals participate in the financing of health care through the payment of different types of fee for service and the payment for drugs and other supplies at both public and private health facilities. Care seekers pay for the total cost of service at private urban clinics and most of the cost at the religious hospitals. They also pay for drugs at most public facilities; in addition, there is an admission fee and other types of fee at public hospitals as will be discussed in the subsequent sections.

Household participation also comes through various community-based activities developed or supported by some NGOs such as CUSO, World Neighbors, the Association Française des Volontaires du Progres, and the Red Cross.

A recent study by the Direction de la Statistique and FED showed that Households in urban areas devote 4% of their total expenditure to health. The study also indicates that the share of health in total expenditure increases with the level of income; this is consistent with other studies findings that demand for health services in developing countries has an income elasticity greater than one. Health services, therefore, appear in this regard as a "luxury good." This has important implications for health policy and cost recovery; in particular, it implies a relatively high dependence of low-income households on the Government and other institutions for the provision of health services.

The study does not show, however, the trends in the household expenditure patterns to permit the analysis of the evolution of the share of health in total household expenditure.

Table F-10

SHARE OF HEALTH IN HOUSEHOLD EXPENDITURE IN URBAN AREAS

%

	Lomé	Other Cities
Income Group		
Low	3.6	3.7
Middle	4.2	4.5
High	5.0	5.0
Overall	4.1	4.2

Source: FED/Direction de la Statistique, Enquête Budget Consommation, April 1990.

D. Cost Recovery and Sustainability

Donors are becoming more and more concerned about the sustainability of future projects after donor funding ends. The issue of sustainability has received increased attention in the country over the past five years due to donor influence and the overall economic restructuring process the country has been going through since the Government adopted the adjustment programs in the early to middle 1980s.

More and more donors are building cost recovery mechanisms into the activities of their projects. Similarly, most NGOs have some fairly effective cost recovery programs which go along with the projects they run. Finally, despite earlier reluctance, the Government is making considerable efforts toward the development of a generalized cost recovery program in public facilities.

1. The Government and Cost Recovery

Until now, there is no broad-based cost recovery program in public health facilities. The Government has always viewed the provision of free health services particularly at public facilities as its duty and the public's civil right. However, there has been a cost recovery system for some types of health services. First the Government has defined a fee for service schedule for care at the CHUs and other hospitals. Second, even at health centers and dispensaries, patients pay for some of the drugs that are prescribed to them. Table F-11 below describes the fee schedule for hospitals

Table F-11

FEE SCHEDULE APPLIED IN PUBLIC HOSPITALS

CFA francs *

		CHU Campus	CHU Tokoin	CHR and HPE
Year instituted				
1982	Consultation		600-1800	300-1800
	Hospitalization (daily)			400-2000
	Deliveries		500	500
1988	Consultation	2000-3000		
	Hospitalization	3000-7000		

Sources: Ministry of Public Health; Ministry of Finance.

As can be seen from Table F-11 above, hospital fees have not changed since 1982, except for the CHU Campus which was not operational in 1982.

Beside hospitals, other public institutions bring revenues to the Government through the existing cost recovery system. The largest contributor beside the CHUs is the Institut National d'Hygiène (INH) which brings in one third of the revenue made at all public institutions beside the CHUs. The INH is a national laboratory which also provides vaccinations for relatively high fees. Table F-12 below summarizes the revenues made by at the Ministry of

Public Health institutions (excluding the CHUs).

Table F-12

REVENUES MADE AT PUBLIC HEALTH INSTITUTIONS

(Excluding the CHUs)

millions of CFA francs

	1987	1988	1989
REVENUES	66.5	73.2	87.3

Source: Ministry of Public Health

The current cost recovery system is going to be broadened to cover more health facilities and more programs. The Government is currently studying in collaboration with UNICEF and WHO how to apply the Bamako Initiative cost recovery program. The Bamako Initiative, which is designed and supported by the UNICEF and WHO, is according to UNICEF, a way to implement the Alma Ata Plan to provide basic health for all. It is a cost recovery program based on the sale of some essential drugs which are provided under generic names and at relatively low prices through UNIPAC. In other countries where the Initiative is already being applied, such as Guinea, there is a mark-up of up to 150% over the UNIPAC cost of the drugs, and the surplus made is used to contribute to the financing of other recurrent costs.

In the case of Togo, the strategy is not well defined yet. However, an experiment is about to start with 21 pilot villages (one in each Prefectures) with an initial budget of \$300,000 provided by UNICEF to cover the first round of the purchase of the drugs.

If it is successfully implemented, the Bamako Initiative program can help the Government raise revenue not only at hospitals but also at primary health facilities. Given that patients usually do not have resistance to paying for drugs, the Bamako Initiative cost recovery program can be effective. However, it has too narrow a base -- only the sale of essential drugs -- and also raises some fundamental equity economic efficiency issues. An ideal system would include other cost recovery mechanisms such as fees for service and price, to the extent possible, each category of service at its true cost.

The World Bank-supported Health and Population project is also

trying to develop a cost recovery system. The Bank, however, is looking for a broader-based cost recovery program.

In any case, the atmosphere at the Ministry of Public Health is much more favorable now for cost recovery at all levels of publicly provided health care.

Beside the UNICEF/WHO-supported Bamako Initiative, there are other cost recovery experiments by other donors such as GTZ and CUSO and some NGOs such as CRS, the Association Française des Volontaires du Progres, the Red Cross, the World Neighbors and others.

2. Cost Recovery Experiments in Some Donor or NGO Projects

The best known of these experiments are found in:

- CUSO's PHV project; and
- GTZ's Maternité de Bé and Central Region Primary Care project;

a. GTZ's Projects

GTZ has fairly successfully built cost recovery mechanisms into its projects. GTZ has always made it clear to the Government during the signing of the agreements of its projects that it would give technical assistance, but not finance recurrent costs. This has probably made it necessary to develop within these projects cost recovery mechanisms.

At the Maternité de Bé a CFA F 2000 fee is charged per delivery. According to some estimates, about CFA F 7 million, the equivalent of 42% of non-salary recurrent costs of the Maternité, is raised through the delivery fees.

There are also other fees such as laboratory analysis fees and fees for other specific services. Unfortunately, the fees collected at the Maternité are turned to the Treasury for its management or spending.

At the Central Region PHC project, GTZ is experimenting with something similar to the Bamako Initiative, where it has provided money to buy a first stock of drugs to be sold and provide surplus to pay for a CFA F 3,000-7,000 salary for the village health agent at the village health facilities where the project operates.

b. CUSO

CUSO has also built cost recovery mechanisms into its Projet

d'Hydraulique Villageoise in the Prefectures of Yoto and Zio. CUSO has introduced revenue-making collective community activities to raise funds to cover some recurrent costs of the project after the donor funding stops. The revenues made are put in Caisses Villageoises which are managed by Village Development Committees. When the fund in a Caisse reaches a certain level, it is deposited at a bank in Lome. In November 1989, the villages had over CFA F 27 million at the bank. These funds are available to the villages and can be used to buy spare parts or rapier the pumps installed by the project.

On the basis of current cost recovery experiments, what projects are sustainable without continued subsidies? Very few if any. Even the most successful cost recovery programs such as the ones at GTZ and CUSO only recover a fraction of recurrent costs.

Generally, projects aim at recovering only non-salary recurrent costs. Now, given that salaries represent about 80% of the Ministry of Public Health's recurrent cost, a cost recovery system which leaves out salaries does not address a fundamental basis for sustainability.

Although the Government is about to start experimenting with the Bamako Initiative cost recovery program, there still is the need to find a broader-based cost recovery system which would include, among others the charging of fees for service in addition to the payment for drugs.

IV. INTERVENTIONS

In this section we discuss the specific interventions in child health which have taken place in Togo during the past few years, their current activities, donor interventions, their effectiveness and impact, and finally, issues which each of these interventions raise in regard to future projects.

A. National Expanded Program of Immunization (PEV)

The PEV began in Togo in 1980 with immunizations in the northern most region, Savanes. By 1984, the program had spread gradually south so that it covered all five regions of the country including the capital, Lomé. Mobile teams carried out most of the immunizations except in the large urban centers. By 1984, immunization coverage was estimated at only 10 percent of children. At the end of 1986-beginning of 1987, Togo began its first mobilization campaign for immunization in response to the WHO declaration of 1986 as the African Vaccination Year. These activities culminated in development of a major campaign for 1988, Action Vaccination Togo (AVT). The elements of this strategy were as follows:

- Social mobilization, preparation of posters and outreach materials, immunization cards, media involvement, public education;
- Training of prefectoral coordinating teams and vaccinators;
- Development of a program to give priority to children under two years old and to women of child-bearing age (12 to 45 years);
- Development of a strategy to equip all health facilities so that immunizations would be available to patients every day (stratégie fixe), while maintaining mobile teams in more remote areas (stratégie mobile) and while developing the outreach capacity of health facilities (stratégie avancée).
- Development of a national immunization schedule.

The PEV is administratively housed in the Division of Epidemiology of the Ministry of Public Health, with the Director of the Division serving equally as director of the program. The PEV oversees the maintenance of the cold chain, distribution of vaccine, and trains local health workers. The médecin-chef supervises the activities in his prefecture, but receives considerable logistical support from the central Ministry in terms particularly of vehicle fuel. The launching of the PEV priority program with annual campaigns has, at times of its peak activity, disrupted the more routine work of the Ministry, and even of other priority programs. Moreover,

a study by Lancon in 1988 showed that vaccination campaigns were not more cost-effective than routine immunizations

The program's major sources of support are two donors: UNICEF and USAID. In 1985, the allocations among the donors and the government were estimated as follows: UNICEF accounted for 26 percent, USAID, 58 percent, and the Ministry, 16 percent. It has proved more difficult to assess present allocations as noted in the CCCD evaluation report of 1990. USAID has provided at least \$250,000 per year through the CCCD program since 1983 with additional input from other sources. USAID's contribution is in terms of technical assistance (long and short-term), logistic and management support, vehicle fuel, vehicles, and measles vaccine. UNICEF has provided all other vaccines as well as equipment and printed materials, with its contributions averaging \$540,000 annually between 1987 and 1989. It is not clear at this time whether the Ministry's contribution to the program is other than in terms of personnel and some vehicle fuel. Two other donors, CUSO and the Peace Corps have contributed to the health education of the activities through their training of community health workers. CUSO also supports the entire immunization program in the Maritime region. The World Health Organization (WHO) and FAC also provide support to central level activities.

Since the launching of the AVT in 1988, the Ministry of Public Health has succeeded in creating permanent immunization sites in the more than 300 health facilities in the country. It has also succeeded in raising the immunization levels of children and of women of childbearing age throughout the country. In 1988 and 1989, surveys estimated that the proportion of children 12 to 23 months old having received at least one immunization was over 90 percent for the country as a whole and for the regions, as well (see Table 6). In 1988, nearly half the children one to two years old had been completely vaccinated (point estimate 48 percent). This level was maintained in 1989 (point estimate 43 percent, not significantly different from the previous year -- see Table 7). During the same period, surveys showed that between 60 and 70 percent of the women of childbearing age had ever received at least two doses of tetanus vaccine (see Table 8). During the year 1989 alone, 18.8 percent of the childbearing women received their second dose of tetanus vaccine. That the program managed to maintain this level of immunization two years in a row indicates that it is beginning to be able to sustain its activities.

TABLE 6
Selected Results of Immunization Surveys

A. Percent children 12 - 23 months receiving at least one vaccination

REGION (BCG)	1988 DHS (any vaccination)	1988 ACT (BCG)	1989 Evaluation
Lomé Commune	-	92.0	92.0
Maritime	92.0	96.0	94.0
Plateaux	93.0	96.0	88.0
Centrale	96.9	95.0	96.0
Kara	100.0	96.0	97.0
Savanes	87.4	92.0	94.0
TOTAL Togo	93.3	95.0	91.0

Source: 1988 DHS: Enquête at de Santé au Togo 1988
1988 ACT: Action Togo Vaccination, 1988
1989 Evaluation: Rapport d'Evaluation du Programme Elargi
de Vaccination, du Programme LMD et du
Programme de Lutte Contre le Paludisme

TABLE 7
 Selected Results of Immunization Surveys, Togo, 1988-1989
 Percent of Children aged 12 to 23 months immunized

Region	1988 (Percent Immunized)					1989 (Percent Immunized)							
	BCG	DTP 1	DTP 2	DTP 3	Measles	Completely Vaccinated	BCG	DTP 1	DTP 2	DTP 3	Measles	Completely Vaccinated	
Lomé													
Commune	92	82	69	53	55	36	92	79	75	61	62	51	
Maritime	96	95	79	52	82	46	94	88	75	52	61	42	
Plateaux	96	92	85	66	77	51	88	78	64	47	62	38	
Centrale	95	94	84	63	76	52	96	95	83	58	68	45	
Kara	96	95	84	66	78	50	97	92	83	57	62	41	
Savanes	92	93	88	75	69	50	94	90	85	68	68	53	
Total Togo	95	92	81	62	74	48	91	84	74	55	62	43	

Source: Action Vaccination Togo, 1988; Rapport d'Evaluation Nationale du PEV, LMD, et LP, 1989

TABLE 8
Tetanus immunizations:

A. Survey Results 1988, 1989: Percent Women of
Childbearing Age (12 - 45 years) Immunized

Region	1988			1989		
	Vat 1	Vat 2	Vat 3	Vat 1	Vat 2	Vat 3
Lome Commune	76	59	37	67	51	26
Maritime	94	83	83	81	67	35
Plateaux	90	82	40	78	64	39
Centrale	92	77	39	91	76	42
Kara	93	82	39	84	65	38
Savanes	83	66	23	73	61	20
Total Togo	83	72	33	77	63	33

Source: 1988, Action Vaccination Togo
1989, Rapport d'Evaluation Nationale du PEV, LMD, et du LP

B. Tetanus immunization doses delivered as a
percent of population of women of childbearing
age (12 - 45 years)

Region	1989		
	Vat 1	Vat 2	Vat 3
Lome Commune	15.1	8.0	11.5
Maritime	27.2	17.8	21.1
Plateaux	22.7	20.0	24.5
Centrale	20.4	16.3	25.0
Kara	21.2	17.2	22.8
Savanes	26.7	24.5	19.0
Total Togo	24.5	18.8	22.3

Source: Vaccination reports, Statistics bureau and
population estimates from Ministry of Planning

(see Table 9). This is possible if health workers are immunizing the same children twice, or if the population estimates are lower than the actuality, or if health workers are reporting inaccurately the number of doses given. The completion rate (third doses of DTP delivered compared to first doses) of 65 percent is a good effort.

TABLE 9
 Immunization Coverage, Togo, 1989
 Children under one year who received immunizations
 as a percent of all children under one year

Region	BCG	DTP 1	DTP 2	DTP 3	Measles	DTP Completion Rate: DTP 3 as a percent of DTP 1 (DTP 3/DTP 1)
Lae Commune	66.1%	51.7%	46.3%	40.3%	31.7%	78.3%
Maritime	124.7	109.0	86.5	68.2	54.4	62.5
Plateaux	104.3	107.7	81.7	61.5	53.2	57.1
Centrale	117.7	113.1	94.9	70.3	66.2	69.2
Kara	95.3	98.2	81.5	67.4	69.2	68.7
Savanes	126.8	133.7	122.5	106.8	119.7	79.9
Total Togo	115.3	110.9	90.0	72.5	65.7	65.4

Source: Statistics Bureau Immunization reports and Ministry of Planning population estimates

The best method of evaluating the effectiveness of the PEV is to examine disease rates. Reported cases of measles have been falling steadily since 1984 with the exception of a serious peak in early 1988. No such peak was seen in 1989. Despite the extensive immunization of childbearing women, 55 cases of neonatal tetanus were reported in health centers with another 18 reported from hospitals. This high number indicates that continued work is needed to raise tetanus immunization levels.

With the assistance of the CCCD project the PEV's management information system and the cold chain have been considerably improved. The program has adopted a standard report on children vaccinated and vaccines used for all health centers and mobile teams. These reports are collected by the Division of Epidemiology which maintains regular surveillance. To assist the Mèdecin-chef to supervise health centers, the Project has developed a supervision check list which is posted in every health facility and which reminds health workers of their responsibilities.

As for the cold chain, recent evaluations indicate that it is maintained well in most centers but will require continued supervision and monitoring. We were told during our field visit of a typical example of logistic problems: when his refrigerator broke down, a health center supervisor was able to store safely his vaccines temporarily in cold boxes, but since going through the bureaucracy to get the machine fixed would have resulted in considerable delays, he advanced out of his own pocket nearly \$200 in order to avoid spoilage. A second problem, not for the health worker, but for the financing of the system is the Government's policy to immunize every day. In consequence, many doses of vaccine are wasted at the end of every day engendering high costs. The CCCD project has undertaken a study in Ogooue prefecture to examine the relative costs of maintaining immunizations daily. Results of this two-year study were not available at this writing. The study design called for Ogooue prefecture to be the experimental group with daily vaccinations and for comparison prefectures to use fixed days. However, we were told during our field visits that nearly all health centers have gone to daily immunizations, so a comparison group may no longer be available for the study.

The CCCD project has also provided considerable training through seminars to local and prefectural health workers. The one drawback of this Project training is that it has been so closely targeted toward the delivery of vaccines that opportunities have perhaps been lost to train health workers in educating their patients about the importance of immunizations or in integrating their immunization activities with the other preventive services they provide.

1. Issues for the future

Three questions should be addressed regarding the future of PEV. First, considering achievements up to this now, does PEV need to continue to be sustained by outside help. At present, the government is apparently investing little other than personnel; vaccines and equipment are provided by donors as are recurrent expenses for transport. The training and supervision seem to have borne fruit, but Togolese supervisors will be unable to maintain these activities without funds for transport and maintenance of equipment (not to speak of replacement when necessary). Thus, some type of continued help will be necessary, but at a lower level than presently. If, in the future, UNICEF phases down its support of immunization programs, as planned, this will leave a larger gap to be filled by the Government and/or other donors.

Second, to what extent should PEV depend upon surveys rather than routinely collected data to monitor implementation. Routine data collection has been proceeding well with the reports arriving in a timely manner and with data processed and available for analysis quickly, at least at the central level. These data provide good estimates of activity. Their estimates of coverage need refinement, as discussed above, but this is not difficult to do. Routine data are needed for managing the program and will be collected regardless. If they can also be used for estimating coverage, then the cost of surveys can be avoided. UNICEF, WHO, and the CCD project have supported surveys for 1988 and 1989. In both cases data were gathered on two additional interventions, malaria and diarrheal disease. Surveys are expensive ways of gathering data, even if one uses the relatively low-cost modified Henderson (WHO) method. Moreover, unless randomization in choice of households is strictly adhered to, biases can occur rendering the results unreliable. It might be preferable for these three interventions to try to derive estimates of coverage and use from the routinely collected data. This same techniques of estimation could be taught to health center workers, so they could gauge for their own catchment areas the extent of coverage. These routinely collected data could then be supplemented every four or five years by surveys.

Third, to what extent should the Ministry continue to maintain the policy of vaccinating on every day even when there is only one child present so that the 19 remaining doses in the vial will be wasted? The program needs to analyze closely its costs in following such a policy. If donor assistance for vaccines is not as readily available as before, some compromises will need to be made between in order to have vaccines available at affordable cost.

Fourth, has the Ministry been successful in moving from a mobile to a fixed strategy for immunizations? The data available to us did not give a way of assessing how much of the activity was

carried out by fixed as opposed to mobile teams. One important change, however, is that Togo's mobile teams are not the classic *Grandes Endemies* permanent mobile teams. Rather, they are health workers from fixed facilities who take turns going out to the field for a week or two.

B. MALARIA

The National Malaria Service was founded in 1952 at a time when it was believed that malaria, as a disease, could be eradicated. By the early 1960s, it was clear that eradication was unachievable and the Service turned its attention more to research. Beginning in 1983-84, with the assistance of CCCD, the Service began in vivo testing of the sensitivity of the parasite, *plasmodium falciparum*, to chloroquine. By 1988, it was evident that there was already some drug resistance at the existing treatment doses of 10mg/kg body weight and even at doses of 25 mg/kg for three days.

Malaria is reported as the major reason for consultation at health centers, constituting one-third of diagnoses (34 percent -- 730,162 cases) in 1989, according to the Statistical Yearbook. In 1987, it was as high as 38.5 percent. However, the National Malaria Services in their 1989 in reporting the number of malaria cases by prefecture, achieves a total of 1,251,340 cases nationwide (the total of the individual prefectures).¹

Among children under five years old, it is also the primary cause for consultation (31.0 percent) with some 225,701 cases reported in 1989. Of the children under five surveyed in the Demographic and Health Survey, 1988, 41 and 46 percent had had an incidence of fever during the past two weeks. Of these, more than 50 percent had been treated with nivaquine (chloroquine). A similar incidence of cases was reported in the *Rapport d'Evaluation National*, 1989. This study estimated that each child experienced 11 episodes of fever per year and that nearly three-quarters of these children were treated with anti-malaria medication.

Of the 4765 blood smears the Services laboratory examined in 1989, 47.8 percent were positive and of these, 99 percent were identified as *plasmodium falciparum*.

In 1989, the Service brought together the senior physicians in the country at Kpalimé and launched a new program consisting of four

¹Since the sources for both reports is the same, the nurses' registers in the clinics, it is difficult to understand how such different figures can arise. Clearly, what nurses report on the *releve mensuelle* is not related to what they report on the National Malaria services report. This makes all the data on malaria cases and chloroquine use seem quite unreliable.

points. First, a new policy for dosage was instituted using an increased chloroquine dose of 25mg/kg. The service designed an eye-catching poster for nurses in the health center that would permit them at a glance to determine the correct dose for each age group. Moreover, the purpose is to retrain health workers to use oral chloroquine and resort to injectable quinine only when the patient is unable to retain oral medication. Second, chloroquine prophylaxis was to be instituted for all pregnant women receiving services in health facilities. Third, the program was to work with village development workers to bring education about the appropriate doses of chloroquine down to the village level. Finally, the service would institute a program of passive surveillance using selected physicians as sentinel sites to monitor drug resistance by taking thick smears for all their patients.

The Service has retained a kind of autonomous standing within the Ministry. It is officially within the Epidemiology Division (although it does not appear there or elsewhere on the organization chart), but it maintains its own laboratory and runs its own clinic. The latter is designed to care mainly for malaria cases but, in fact, serves simply as a regular clinic, a vestige of the old colonial Grandes Endémies system.

The Malaria Service distributes chloroquine to health centers -- in addition to the allocation that health centers receive from central Ministry stores. In 1989, the Service received 3 million pills of 155 mg from WHO and 7 million pills of 100 mg from UNICEF. Through the CCCD program, the Service received 6 million pills of 100 mg in 1988 and 8.5 million pills in May 1990. The Service stated in its 1989 Report that it distributed 5.5 million pills that year. During our field visits, we observed that there were at least two sources of supply and there was some confusion about them. The Service has instituted two monthly reports. The first tracks the number of new cases of malaria diagnosed and the amount of chloroquine dispensed. The second report notes the number of pregnant women receiving chloroquine prophylaxis. The Service produces an annual report. Their data on the number of cases of malaria are nearly double those listed by the Statistical Service (1.25 million as opposed to .73 million). Since the sources of the data are the same (the consulting nurse's register), these widely divergent results indicate the extent of mechanical reporting errors in the duplicate systems.

The Service receives support from several donors, particularly UNICEF, WHO, USAID, and FAC. The CCCD project has supported the chloroquine supply and logistics management. It has also provided technical assistance for in-vivo studies.

1. Issues for the future

One major issue for the program is how much it should remain organizationally autonomous from other programs. This verticality

has created problems for its programs now that it is involved in primary care delivery and in health education. There seems to be little reason for its drug distribution system to remain separate from the routine Ministry allocation of drugs nor should it maintain its own data information system and even separate clinical facilities. Any new donor programs, or even extensions of earlier activities should consider integrating them, where feasible, with other related Ministry activities in health education, information systems, and drug distribution.

A second issue is how much effort should be expended in vivo research to identify drug resistance. According to the Malaria Service officials, the present system of sentinel sites is apparently not working well, so far. Only 1269 tests were received last year. Such a program is expensive to maintain since physicians must do follow-up blood smears on all their patients and the Service must be able to assure that these laboratory tests are reliable. The argument has been made that without the earlier studies, the decision to increase the treatment dose of chloroquine would never have been made. In fact, the increased dosage is one that had been recommended internationally for some time and was being routinely adopted in other countries. Drug-resistant malaria is an international phenomenon and can be studied in many countries. These studies may, in the long run, collect valuable data that can improve malaria treatment, but the results will be mainly of interest to international epidemiologists, not to Togolese health planners. Therefore, we would not recommend that such research programs be actively supported.

C. Combatting Diarrheal Diseases

1. Current Activities

The Ministry of Public Health program for the Lutte Contre les Maladies Diarrheiques (LMD) began in 1983 as one of the three CCCD initiatives. The central Ministry activity in the program is under the Division of Mother and Child Health (DME) which is responsible for defining the national policy, planning and supervising its implementation and evaluating the results. The program receives significant support from UNICEF through donation of oral rehydration salts (ORS), training and IEC support. An Ad-Hoc Intersectoral Committee on LMD was initiated in 1987 and has been incorporated into the Sub-Commission on Transmissible Diseases under the National Commission for Child Survival, created in March 1989.

The central strategy of LMD is to promote the use of ORS packets and, when they are not available, a sugar and salt home solution (SSS). This strategy is implemented through training health providers in the use of oral rehydration therapy (ORT). A major

effort has been made to discourage the use of previously favored treatments which included guanidine, charbon and antibiotics.

Médecins-Chefs and heads of services were trained in 1989 in the basic ORT program. Other health education programs, including the Peace Corps/National Service of Health Education pilot program and the Child Nutrition Centers of CRS/Ministry of Social Affairs, have included ORT as a major component of community level education.

The CCCD program has funds to provide support for the construction of a national ORT training and demonstration unit at the University Teaching Hospital in Lome, however construction of this unit has not yet been completed -- due to USAID architectural requirements. Similar units in Regional Hospitals at Sokode and Kara are also not operational, although they have received the necessary equipment and supplies. Planned ORT corners in periphery health facilities have also not yet been implemented, although personnel at this level have been trained to develop the ORT corners.

CCCD technical assistance has not been as intense in this area as it has been in malaria and PEV. CCCD has supported the information system for the Division of Maternal and Child Health and has provided some IEC materials. It has not, however been able to establish clear counterpart relations in the Division.

UNICEF plans to continue providing free ORS packets through the next five year program. The five year UNICEF budget for ORT materials and activities is US\$300,000.

2. Effectiveness and Impact

The LMD program has not yet demonstrated significant advances. ORS use is still low, health facilities treat only a small percentage of the cases and many are not providing proper treatments. IEC materials are not readily available.

The 1988 Demographic and Health Survey found that 29.4% of the children under 5 years of age had had diarrhea during the previous two weeks. ORS packets were reported to be used in 20.4% of the cases, while the sugar and salt solution was reported only in 3.2%. Utilization in rural areas was considerably lower than in urban: 21% in rural areas used either ORS or the home solution compared to 31.7 in urban areas.

The recent mothers survey for the Ministry evaluation of the program (October 1989) found an average of 5.3 episodes of diarrhea per child per year of which 69.1% were treated in some way. Of those treated only 13% were treated with ORS or the home solution, while 47.1% were treated with pills -- guanidine, charbon or Tetracycline. Only 1.6% reported using the home solution, suggesting that the promotion of SSS has not had an effect.

Overall in only 22.4% of the cases did the mother seek treatment at a dispensary (and 8.6% at hospital). [Rapport d'Evaluation Nationale du PEV, LMD, Paludisme -- see above Section I.D. for comments on the quality of data in this report and in the DHS]

The 1989 evaluation also surveyed health facilities and found in general that not all cases of diarrhea that appeared at health facilities were being treated by ORS. In the Maritime Region, 94% were treated with ORS; however in other regions the percentage of treatment with ORS was less, with Savanes the lowest: 73%. The survey found that almost half of the treatments for diarrhea included other medicines in addition to ORS -- suggesting that health workers are not fully conforming to the national strategy. In all regions several health facilities in the sample reported stockouts of ORS packets during the previous year.

The evaluation also found the market was the major source of treatments (55.2%); even for ORS packets (64.3%). However, this data is on very small samples and is not reliable. It seems unlikely that ORS packets which are free at facilities are being purchased in such quantities in markets.

3. Issues for Future

Clearly greater efforts are needed in this program. A published national strategy has yet to be established, health education materials have not been developed and distributed on a mass scale. Greater efforts should be developed for increasing access to SRO in the home -- through social marketing mechanisms and community based distribution.

The policy of promoting home solutions should be reevaluated. Studies of the salinity levels of salt and sugar solutions in other countries show a high potential for sodium toxicity. Alternative home solutions should be evaluated. Operations research studies should be initiated to determine effective means of training periphery health providers to teach mothers how to prepare and utilize the solutions.

It is our belief that the Ministry should focus on making SRO available in the home (through liberal distribution from health facilities, community based distribution and the market) and also use health education to emphasize the use of any fluid and breastfeeding, rather than promoting the complicated sugar and salt home solution. In any case, a clear policy needs to be established as soon as possible.

Of the three major interventions of the CCCD project, the LMD has been the weakest. A future effort in CCCD or similar project (or project component) should focus more direct effort and technical assistance in this area. Special attention to IEC issues in ORT

should be addressed.

Perhaps most important, the project should also assist the integration of efforts of other Ministry programs -- especially the National Health Education Service (SNES), Growth Monitoring and Nutrition, as well as extra-ministerial programs, such as the Centers for Child Nutrition supported by CRS and the Ministry of Social Affairs.

In the new Ministry of Public Health reorganization plan described in the World Bank Aide Memoire, no specific unit has been assigned responsibility for the ORT program. However, the proposed strategy does place high emphasis on this program. Presumably it will be part of the Service de Sante Maternelle et Infantile.

D. Family Planning

1. Population Policy

The law of July 31, 1920 prohibiting induced abortion and dissemination of information on contraception, represents the official written policy of the government. However, the government always has adopted a positive attitude towards family planning activities (FP). The creation of a national program of Family Welfare in the Ministry of Public Health (PNBEF) and a private component of FP for the Family Welfare (ATBEF) an affiliate of the International Federation of Family Planning (IPPF), to promote Family Planning activities at the national level, are the evidence that the GOT wishes to associate family planning to its development efforts. Although a national policy document has not yet been approved, a conference on this matter was held in September 1987 in Lome. This conference received technical and financial support from RAPID/NAPRO program. This program is financed in Togo by UNFPA, the Agency for International Development and the World Population Society. This 1987 conference defined the national objectives to improve living conditions of the population in order to allow them participate fully in the social and economic development by bringing the population growth to a rate consistent with the economic development. A second conference organized in September 1988 at Kpalime has also permitted to formulate government directions concerning population activities. To fulfill this objective, the government envisages to:

- a. promote awareness about population problems and the consequences of rapid population growth on social and economic development among Togolese
- b. provide every citizen with necessary information and education on the advantages of a planned family

- c. educate the youth on population issues, sexuality, regulation of fertility and family planning in order to keep up a responsible procreation
- d. provide the population with fertility regulation program at reasonable costs and which meet the needs of the population
- e. improve ways of gathering and analyzing population data to better integrate population factors in the process of social and economic planning.

2. Family planning Activities

Family planning activities are carried out mainly by the two institutions: The National Program for Family Welfare (PNBEF) and the Togolese Association of Family Welfare (ATBEF). The PNBEF manages forty state health structures which provide all methods of family planning services. One-third of the 350 clinics provide non medical contraceptives (spermicides and condoms). PNBEF has started a pilot project in two of the five economic regions of Togo (Kara and Maritime) with the financial and technical support of UNFPA. The objective of this project is to achieve technical and material reinforcement of PNBEF in order to strengthen and expand family planning service delivery to 120 sites at the level of the two regions. PNBEF plans to standardize clinical procedures and improve the management of statistical data related to family planning activities. It also plans to supervise contraceptive and equipment distribution through Pharmapro. A senior technical advisor from UNFPA is assisting PNBEF in the implementation of this project.

ATBEF, an IPPF affiliate, has a family planning clinic of in Lome which serves as a training center for service delivery. Seven regional coordinators work for ATBEF in the national level. ATBEF employs 15 motivators who carry out awareness activities and service delivery of non clinical methods at the village level. ATBEF stores and distributes contraceptives in all health centers with family planning activities. It receives monthly reports on the use of contraceptives throughout the country except in the Golfe Prefecture where PNBEF has initiated a new system of data collection on family planning activities. In general, Family Planning in Togo has not yet been integrated to mother and child care activities. The supervision of the activities is almost absent due to the lack of management system, human and material resources. There is no structured private sector delivery service of family planning.

Most of the 46 private clinics and religious hospitals deliver family planning services, but these activities are difficult to quantify because of the absence of documentation standard. Some

NGOs like World Neighbors, Christian Children's Funds (CCF) integrate family planning activities into their programs.

3. Donors' Contribution

USAID: 1988-1991

The Family Health Initiatives Project (FHI-II) provides \$1.5 million from 1987 to 1990.² The Project funds the training of service providers in 27 health centers.

The 27 health centers include 3 mother and child care centers in Lome, 4 regional hospitals and 19 mother and child cares centers in the prefectures. The technical assistance for training has been provided mainly by INTRAH. INTRAH has established a team of national trainers to increase the institutional capacity of the Mother and Child Division (DME) to organize training courses. ATBEF stores and distributes contraceptives provided by the project. Financial assistance has been provided for the development of a population policy. The project financed community distribution of contraceptives by the eight ATBEF motivators. IEC activities of ATBEF have been reinforced by PSC technical assistants. Finally, short-term training courses for ATBEF personnel have been financed for the personnel in charge of IEC, logistics and administration of the program.

UNFPA: 1990 - 1994

The objective of the Project is to strengthen the Mother and Child Division (DME) in order to coordinate and manage family planning activities in Togo. At the end of the project, the family planning unit of the DME will have received personnel training, copying machines, computer equipment and vehicles. Two medical doctors have been recruited for supervision, and an administrator and a driver have been hired. The training of 90 nurses at the operational level will enable these nurses to provide all methods of family planning except the IUD insertion in the Kara and Maritime regions. Forty-five centers in the Kara region and 45 centers in maritime region will be equipped and operational to deliver family planning service from now to late 1992. Forty health posts in the region of BIANKOURI will be equipped for non-medical family planning delivery services. An integrated monitoring/supervision system will be set up in the two regions.

The project plans the integration of the family planning statistical data base into the statistical data of the Ministry of Public Health and the establishment of data processing at the DME.

² A no cost extension of the project is planned up to September 1991.

After 1991 a training curriculum will be integrated in the basic family planning courses for medical doctors, midwives, nurses and medical assistants. The project plans to include contraceptives and medical equipment in the usual distribution channels of the central pharmacy. Finally, the project is considering financing the construction of a family planning pilot center in Lome capable of providing all family planning services. UNFPA envisages the creation of an Information, Education and Communication (IEC) unit within the Ministry of Social Affairs and Women's Condition.

Assistance for the general population census is also scheduled and the integration of population education in school program are also scheduled. Budgetary planning are the following for the period of 1990-1994:

	US\$
a. mother and child care and family planning	1,350,000
b. Information, Education and Communication	900,000
c. Population census	1,000,000
d. Formulation of a population policy	600,000
e. Population dynamics	500,000
f. Women, population and development	450,000

INTRAH: 1987-1991

Under the Family Health Initiatives Project, INTRAH has been responsible for providing technical assistance for training to PNBEF.

Objectives of the buy-in were to:

- a. provide assistance for the constitution of a national team of trainers
- b. training of 260 service providers (midwives, nurses and social workers)
- c. assist in the setting up of regional training teams

To achieve these objectives, in collaboration with PNBEF INTRAH has developed curricula in IEC training, family planning clinic and management; organized a series of training of trainers seminars at the central and regional levels and held practical training for monitors in four clinics in Lome. INTRAH has also provided for a period of 9 months a resident advisor to PNBEF who has supervised the development of an inventory of resources

available in the project's 27 centers. Inappropriate choice of participants to training courses and the unavailability of national monitors have prevented teams of trainers from becoming fully effective. INTRAH has therefore reorganized its assistance strategy by giving priority to drafting a national family planning policy and standards. These standards have been recently approved by the Minister of Public Health but are still awaiting approval from higher Governmental levels.

INTRAH plans to organize with DME, a workshop to disseminate these standards during the next months. This workshop involves preparation of a protocol, development of new training schedule which will be supplementary to training planned by UNFPA, a revision of curricula and setting up of an appropriate system of supervision.

Finally, INTRAH plans to recruit a technical assistant to help DME achieve these new objectives.

SEATS/John Snow, Inc.: 1990-1994

During the period 1990-1994, the SEATS project plans its support of family planning activities in two phases. The first phase, (June 1990 - July 1991) or consolidation phase has as objective to help set up in PNBEF management tools and mechanisms necessary to reinforce and extend services at the national level. For these reasons, SEATS will:

- a. finance training in supervision technique of two physician supervisors in the Kara and Maritime regions
- b. provide its technical support to the drafting of a protocol of clinic supervision and a supervision plan of family planning activities in the two pilot regions
- c. finance the setting up of standard procedures of financial and administrative management and the recruitment of an administrative and financial director for the DME
- d. offer its technical support to the conception, the setting up, the follow-up and the evaluation of a standard management information system for family planning integrated into the national health information system
- e. provide a consultant to PNBEF who will assist in establishing a contraceptive cost recovery policy in collaboration with UNICEF, the project Child Survival, GTZ and ATBEF. A consultancy is planned for the feasibility study of transfer of the responsibilities of

contraceptive distribution at the national level from ATBEF to Pharmapro.

SOMARC: 1990-1994

A study conducted in April 1990 by a team of SOMARC revealed that there is a favorable political and social environment for a program of Social Marketing of Contraceptives in Togo. The objective of the program will be to increase the use of modern methods of contraception within the middle class in the urban areas and rural areas to 50% for the condoms and spermicides, to 15% for the pills during the next four years; to commercialize these contraceptive methods in structured commercial private sector and to train dealers on the characteristics of these methods; to design the cost recovery mechanisms to make the program autonomous in the long term.

ATBEF is the institution which has been proposed to coordinate activities of this program whose local cost is estimated to \$200,000. Constraints related to the implementation of this program include laws restricting publicity on contraceptives, on the prescription of medical contraceptives, Togopharma's monopoly of the import and distribution of pharmaceuticals and finally the limited networks on means of distribution in the commercial sector.

EUROPEAN DEVELOPMENT FUND (FED): 1988-1993

The European Development Fund is financing a family planning project in the Savanes Region through ATBEF. This project covers the period 1988-1993 for an amount of ECU 176,000. ATBEF is implementing under this project, training activities for medical personnel and awareness activities for the population.

4. Effectiveness and Impact of Family Planning Program

After fifteen years of family planning activities in Togo, the 1988 DHS survey revealed that the large majority of Togolese women know at least one contraceptive method (93.5%), and a source of supply (81.3%). However, only 3% of women were using modern contraception when the survey was conducted.

The general knowledge about contraceptives does not translate into their general use. The limited number of family planning clinics, the legal barriers and centralization, have hindered the rapid diffusion of hormonal methods (pills) compared to barrier methods (condoms and spermicides). Family planning activities are concentrated in towns and in county towns of prefecture. Long-term contraceptive methods and surgical contraception represent a tiny part of family planning services provided to clients. Maintenance of family planning services without charge to the client in the public sector is a practice that threatens program survival and

autonomy since it prevents the partial recovery of the costs related to its activities.

5. Issues for the Future

Studies conducted by the Unite de Recherche Demographique (URD) reveal that socio-cultural constraints remain important in Togo. Having a large number of children is considered a sign of wealth. On the other hand, religion seems to have a more limited influence on decisions regarding family size. Another constraint is related to the dominating role played by men in the society. Although no law requires it, wives are always asked to present a written agreement from their husband before receiving family planning services. The free sale of contraceptives, most of them time-expired, in the marketplace contributes to the bad repute of family planning. The number of family planning sites within medical facilities remains limited compared to the demand. The law of 1984 prevent schoolboys and teenagers from protecting themselves against unwanted pregnancies and abortions. The centralization of the hierarchical system forbids any initiative at the regional or peripheral level. The institutional weakness of PNBEF (limited personnel and expertise), lack of management tools (clinic protocols of supervision, management of information system) and the lack of integration of SMI/PF activities are the handicap for rapid extension of family planning activities at the national level.

On the other hand, the recent approval of family planning service delivery standards by the Ministry of Public Health, its intention to decentralize and integrate family planning services into preventive health activities with the support of the World Bank, the location in Lome of the Regional Bureau of Population, and support from the UNFPA for reorganization of PNBEF are the major assets for the success of the family planning program.

a. Choice of Local Institution

ATBEF has received continuous funding for fifteen years from donors, mainly from the IPPF. ATBEF received also funding from USAID under the Family Health Initiatives II (FHI-II) for health education, distribution of contraceptives in the state health centers and community distribution of contraceptives by motivators. Different evaluations conducted by USAID, IPPF showed that ATBEF is a dynamic NGO, well managed and which contributes significantly to family planning activities in Togo. On the other hand, the PNBEF, with sporadic support from donors, was not able to develop sufficient institutional capacity for the sound management of family planning activities.

Nevertheless, since the start of the UNFPA project with DME, renewed energy has been infused into the public sector. DME is being strengthened in human and material resources and family planning program management tools are being set up. The project

to reorganized the Ministry of Public Health (financed through the World Bank loan) aims at the integration of all preventive activities particularly maternal and child care and family planning.

Thanks to this new support, DME is planning a progressive extension of family planning services delivery sites at the national level. It is recommended that USAID participate in these institutional strengthening activities. DME should be considered as the principal implementing institution of activities relating to mother and child care. Therefore, the objective of further assistance to ATBEF should be to complement Ministry of Public Health activities by orienting ATBEF towards the private sector and its health education activities.

b. Integration and Decentralization of Departments

The current system of family planning service delivery is not the same in all centers. Family planning are considered as minor activities or as luxurious service. One of the priority objectives to continue within the scope of the new project would be the effective integration of all SMI/PF activities. The expected result would be that all SMI/PF services would be offered every day. The need for a planned and integrated training program for health professionals is urgent. The decentralization scheduled under the World Bank project would give more responsibilities to the medecins-chefs who could then supervise these activities more fully.

c. Health Information System

The health information system of SMI/PF activities is neither efficient nor adapted to the needs of program. There are duplication and multiplicity of statistical supports which are not facilitating the management of the system. Most of the data on family planning are sent to the ATBEF. Information necessary to the improvement of the program are not available. A new system of data collection has been initiated by the UNFPA project in the Golfe Prefecture. A coordinated structure is needed at the central level to supervise the application of the new integrated health information system which will include data on SMI/PF. One of the first tasks of this structure will be the synthesis and simplification of the report forms by taking into account the needs of each level of the program. This new program must allow the self-evaluation of service delivery at the periphery, supervision at the regional level, evaluation of the objectives and resources at the central level.

d. Contraceptives

Contraceptives in Togo come from several sources. The largest part is provided by USAID under the Family Health Initiatives Project. About \$350,000 are spent every year in Togo. This high cost is related to the profile of contraceptive consumption which is oriented particularly toward condoms and spermicides. IPPF and UNFPA provide lesser quantities of contraceptives. UNFPA also distributes Noristerat on which an operational research project is being conducted.

Coordination among the donors, ATBEF and PNBEF for the supply of contraceptives is wanting. In the future, USAID should concert its aid in long-term collaboration with other donors. In view of an extension of family planning program, it is appropriate to initiate a contraceptive cost recovery system in the public and private sectors within the framework of the Bamako Initiative. It is also appropriate to consider the feasibility of a transfer of responsibilities of contraceptives distribution from ATBEF to the Ministry of Public Health or Togopharma. The funding for this transfer will enable contraceptives to flow through the same channels though which basic drugs are distributed to the medecins-chefs. Such a distribution system would help in establishing a national policy of cost recovery.

e. Extension of Family Planning Services

The health and population survey conducted in 1988, revealed that activities of awareness have proved to be positive. The large majority of women had heard of modern methods of contraception, but only three per cent are using these methods. Therefore, there is a potential need for family planning services because 70% of them wish to use one of these methods in the future. Support to the extension of family planning services is necessary to the three regions not covered by the UNFPA project.

This support can be shown in the form of support to training of medical and para-medical personnel, reinforcement of the national team of trainers, supply of standard equipment for SMI/PF activities and setting up of an integrated and standard health information system. Support to ATBEF for the extension at the national level of family planning activities to the private sector is desirable in order to increase the variety of sources of contraceptives supply. The initiative of social commercialization which will be managed by ATBEF needs to be supported and expanded to the informal sector of contraceptives distribution.

f. Research - Evaluation

To allow a continuous evaluation of Togolese population dynamics, and in order to favor an integration of population data into development planning, it is desirable that financial assistance be

provided to support the general population census project. Financial and technical support is also necessary for the second DHS survey in 1983. This support will provide the means to evaluate the development of MCH services since the first survey in 1988.

E. Nutrition and Supplementary Feeding Programs

1. Nutrition Status

The 1988 Demographic and Health Survey found that 30.6% of the children under 3 years of age suffered from chronic malnutrition (measured by height for age). Only 5.3% suffered from acute malnutrition (measured by weight for height) at the time of the survey which occurred during post-harvest season. Regional variations, however, were great. Savanes Region had 41.8% chronic malnutrition and 23.7% acute malnutrition, while Maritime Region had 25% chronic malnutrition and only 1.8% acute malnutrition.

The study also found that most of the cases of infant diseases (with the exception of ARI) were associated with malnutrition.

Anemia is the major nutritional disease in Togo. According to a OCCGE nutrition survey in 1985, 72.6% of children 6 to 60 months, 30.5% of newborns, and 48% of pregnant women (at nine months) are anemic.

Current routine hospital statistics show 10% of hospitalizations and 14% of the hospital deaths are due to anemia.

Endemic goiter is also prevalent in five prefectures and in pockets in other parts of the country.

2. Current Activities

The major Ministry of Public Health nutrition activity is the responsibility of the Growth Monitoring Unit within the Division of Maternal and Child Health. This unit participates in the National Nutrition Commission which includes the Ministry of Plan, Ministry of Rural Development and the Ministry of Education and is supported by UNICEF, CRS, OCCGE, FAO, and WHO. In 1989 this commission prepared and published a National Food and Nutrition Policy which includes both nutrition and food security components.

One of the recent achievements in growth monitoring is the development of a national standard Growth Monitoring Card. The card is based on the WHO model, adapted to national needs and was field tested in December 1989. This card will replace the variety of separate private models that are currently in use. It will be the first time the Ministry of Public Health will have a growth

monitoring card, although Ministry of Public Health facilities have had weighing programs in the MCH (PMI) units.

In the PMI units of dispensaries and other peripheral health facilities the weighing program will use Salter Scales provided by UNICEF (at the current time only approximately 20 Dispensaries have these scales), while the community programs in communities will use Talc scales that allow mothers to place the Growth Monitoring Card into the scale and mark the weight directly on the card. The Ministry of Public Health has had training programs for PMI staff.

The community program is being designed with the Ministry of Social Affairs and Women's Condition to be progressively introduced throughout the country over three years. In 1990, the program is to cover Kara and Maritime Regions, followed the next year by Savanes and Central, with Plateau covered in 1992.

Most of the Ministry of Public Health program has been funded by UNICEF, with additional assistance from WHO.

Breast feeding is a common traditional practice; however, significant weight loss tends to occur at weaning. The Ministry of Rural Development's Division of Nutrition and Food Technology has developed two weaning formulas; however, there has yet to be a national program to promote them. The Division of MCH plans to train midwives to demonstrate and promote these weaning porridge. CRS has also promoted research into several formulas of weaning porridge.

The National Nutrition Plan has established objectives for addressing iron and vitamin deficiencies. The Plan also calls for the creation of 27 Nutrition Recuperation Centers (CREN) to treat protein-caloric malnutrition in severely malnourished children. However, no clear action has yet been initiated. To address the anemia problem in pregnant women, UNICEF has provided iron and folic acid pills which the DME is preparing to distribute to PMI units.

The Ministry of Public Health restructuring will not change the location of the nutrition unit. The Nutrition Service will be within the Division of Family Health of the Primary Health Directorate.

PL480 Title II Programs

The PL480 Title II program is managed by Catholic Relief Services (CRS) and its national counterparts, the Ministry of Social Affairs and Women's Condition, the Ministry of Education and Caritas/Togo.

Their major initiative involves 83 Child Nutrition Centers (CNI) attached to the Social Centers of the Ministry of Social Affairs

and Women's Condition and Women's Condition. These Centers receive PL480 Title II food supplements (bulgur wheat, wheat soya mix, and cooking oil). The nation-wide program is supervised by regional supervisor teams including CRS supervisors and Ministry of Social Affairs and Women's Condition supervisors. The Centers are managed by Social Affairs Agents and have auxiliary agents in the associated villages. The program encourages the formation of Mothers Committees to participate in the Centers' management.

The program covers 93,000 people with a monthly ration to registered mothers with children under-five. Each mother pays a contribution of 200 CFA per month for a 5 kg food packet with bulgar wheat, wheat soya blend and oil from the PL480 donations. During drought, this ration has been doubled in affected areas. Administrative and transportation costs of this program are funded by monetization of part of the donated food. When the mothers and children come for their food ration, the children are weighed and mothers are given health and nutrition education. The program just published a Health and Nutrition Education Guide, which is to be distributed to all Centers to assist the Social Affairs Agents prepare their health education talks. Topics included in the Guide cover basic nutrition, immunizable diseases, diarrhea, malaria, clean drinking water, intestinal parasites, and family planning. Centers also have demonstration gardens. This program was the subject of a two year operations research project which identified improved methods for organizing health education sessions and provided incentives for local problem-solving and improved supervision techniques.

The second supplementary feeding initiative provides a noon meal for 72 primary schools in the country (17,000 students) -- only a small portion of the total number of schools. The schools are provided with PL480 Title II food for the lunches. Each child contributes 100 CFA a month for 20 meals. Half of this quota pays for meat, fish or poultry that is added to the meal. Schools also are provided technical assistance for gardens. CRS is working with the Ministry of Rural Development to develop alley crop methods for nitrogen enrichment of garden soil in 10 pilot schools.

CRS and the Ministry of Social Affairs and Women's Condition also manage a small Humanitarian Assistance program to provide PL480 rations for emergency situations. This program provides assistance for approximately 6,000 beneficiaries a year.

3. Issues for the Future

a. Growth Monitoring and Nutrition Education

The Ministry of Public Health growth monitoring program is just getting off the ground so it is too early to evaluate the effectiveness of the program. It is clear, however, that much

greater effort to strengthen the PMI weighing program and to improve a variety of nutrition education opportunities -- at the PMI, in the community, at schools, and in the CNI are necessary. Even at the CNI where a major focus has been on nutrition education and counseling of mothers, contact with mothers averaged 43 seconds a month according to the operations research studies. Improved means of effectively using these opportunities and to evaluate their impact on changed nutrition behavior in the home should be a focus of specific interventions in future projects.

Given the strong relationship between malnutrition and diarrheal disease and with both nutrition and IMD in the same Division, greater coordination in training and health education should be supported.

The CNI growth monitoring and nutrition education activities appear to have been strengthened by the operations research project and are likely to be the strongest nutrition education programs in the country. However, their targets are limited to the beneficiaries of the feeding program. The education model they use should be evaluated for incorporation into the Ministry of Public Health nutrition programs.

In terms of reporting the growth monitoring data, the CNI do not now report to the Ministry of Public Health statistical service. With the implementation of a national growth monitoring card, this reporting should be possible.

Indeed, as we discuss below, much greater interchange between the CNI program and the Ministry of Public Health program should be promoted.

b. Feeding Programs

The PL480 Title II feeding programs raise several important issues.

First, the CNI program provides rations without regard to any targeting criteria. Selection for the program is not limited to the lowest income groups, nor to the families with identified nutrition problems. The government appears reluctant to attempt to initiate a means test or other mechanisms for targeting the food to those in greatest need. Some linkage to the weighing program, however should be explored.

The CNI also provide an incomplete service in growth monitoring in that they do not have the skills nor the means of identifying and treating nutrition and diarrheal problems. They can identify lack of weight gain and can counsel the mother. However, they cannot provide a clinical review and treatment of the case. This review and treatment should be available in the Ministry of Public Health health facilities.

Several options for changing the program to address this issue might be considered:

1) the bulk (perhaps 80%) of the feeding program might be shifted to the Ministry of Public Health facilities where it would provide an incentive for mothers to have monthly weighing and where case review and treatment could be provided for the cases of malnutrition. The CNI could then focus on the identified cases (perhaps 20%) and provide focused health and nutrition education for this target group. This new division of labor might make better use of the stronger education skills of the CNI staff.

2) even with a continuation of the current feeding program in the CNI a clearer policy of referral and information flows between the CNI and local health facilities might be established. All cases that do not show the expected weight gain according to the chart, could be referred to the nearest health facility. Monthly reporting from CNI should be routinely provided to the nearest facility and to the medecin-chef.

At a more fundamental level, it is not clear that the feeding program is much more than an income transfer to an untargeted population. Except for the opportunity to provide nutrition education, it is not really a nutrition program. In addition, it may have detrimental dependency implications, especially since it provides foods that cannot be produced in the country.

There are, however, other development objectives that might be served through the provision of food to a larger number of schools. In other countries, it has been shown that school feeding programs, if they provide sufficient incentive to balance the economic loss of the child's labor, can be an effective means of reducing drop out rates. Also if a breakfast is provided students tend to be more alert for morning sessions and learn more. If the PL480 program shifted its focus from CNI to give greater attention to the school component, it might have a greater impact on education objectives.

The difficulty of this approach, as with an approach that shifts PL480 resources from the CNI to the Ministry of Public Health facilities is one of bureaucratic turf. The Ministry of Social Affairs and Women's Condition is now the major counterpart of the CRS program and is likely to resist any shifting of resources to other ministries. A gradual program of enlarging the role of the other Ministries, however, might enforce greater integration and more effective use of the resources.

F. Maternal Health/Safe Motherhood

The Ministry's safe motherhood initiative forms the major part of its maternal and child health program (SMI). During the past few years, the Ministry has gradually expanded its SMI program to include all the more than 300 hundred health centers around the country. The goals of the program are to increase to 80 percent the number of pregnant women consulting in health centers during pregnancy, to improve the quality of the surveillance and deliveries through training, and to improve follow-up. Plans are being developed not only to re-train birth attendants, but also to train traditional birth attendants to increase the number of qualified personnel assisting deliveries.

The objectives are also to increase the vaccination coverage for women of childbearing age. The maternal health program's activities are to provide prenatal and postnatal consultations, tetanus vaccinations, and delivery care. In a few of the larger centers, this care is delivered by midwives, but throughout most of the country, birth attendants or clinic nurses are the primary providers. The program has recently instituted a new recording and information system, using a standardized patient record and standardized reporting form. In April of this year, the program issued a guide for use by all those doing prenatal consultations. The consultation patient record and the guide help the health worker to identify pregnant women at risk and to know what action is appropriate to take.

This program has been supported particularly by UNICEF and by WHO whose input is mainly in publication of materials. UNICEF is continuing its program through 1994 with an expected annual input of \$250,000 per year of which two-thirds goes for the prenatal program. GTZ supports the maternity of Bé and the midwifery and birth attendant training programs associated with the institution. We were told that the whole SMI program, in fact, survives by living off related vertical programs, such as PEV, diarrheal disease, and family planning. For example, UNFPA has placed a technical advisor in the DME to assist with family planning, but he also helps on all maternal and child health activities of which maternity care is the largest part.

At present, data on the impact of the program are limited. During 1988, 75,472 deliveries were reported as taking place in health centers. This constitutes about 55 percent of all estimated newborns. In mid-1989, UNICEF sponsored a survey of the quality of maternal and child care at 30 randomly selected rural dispensaries. The authors found that at the clinics surveyed only 36 percent (+ or - 31 percent) of the births were covered. Since the standard error of the mean is so large, the actual figure lies between 5 to 67 percent. This does not give the degree of precision one would like to have to evaluate program effectiveness. Women were more likely to seek prenatal care, than to conduct their delivery at the

center, with 69 percent (+ or - 20 percent) actually seeking care. The observers at the clinics noted that the care tended to be delivered in assembly line fashion and that although urines were tested 95 percent of the time, many other activities received less attention: weight (56 percent), anemia screening (34 percent), blood pressure check (26 percent). Sixty-five percent of the time, birth attendants assessed the vaccinal coverage for tetanus. Prophylactic chloroquine doses were distributed to 86 percent of the patients, but none received iron supplements. The report concluded that birth attendants should receive regular supervision so that the theory they learned in training could be applied in the field.

Issues for the future

Since this program is closely tied with the family planning program in terms of the population served and the health workers who staff it, we would recommend that some support from USAID in this activity would help integrate these two programs.

G. Dracunculosis (Guinea worm)

Guinea worm infestation has become endemic in certain districts of Togo, posing, in some areas, an important public health problem. The latest data from a survey conducted in November 1989, and analyzed by UNICEF in March 1990 showed that guinea worm is endemic in 16 of the 21 prefectures. Although irregular and isolated, several other epidemiological surveys from 1984-1988 have given estimates which include incidence rates of 30 to 65 percent in villages in certain districts.

The disease is generally found in rural areas where the populations depend on contaminated pools or shallow wells for their source of drinking water. The peak of disease incidence occurs during the height of the agricultural season causing a particularly inconvenient morbidity at a time when farmers need to be out in their fields.

As part of a global effort, the Government of Togo this year has launched a national plan of action for the eradication of guinea worm. The plan uses a multi-sectoral approach involving the Ministries of Public Health, Social Affairs, Rural Development, and Equipment, Post and Telecommunication. A national committee (CNEVG) established by a decree dated April 1990 is to define the government's policy.

The estimated cost of the national plan for five years (1990-91 - 1995/96) is \$494,920. Sources of finance have not yet been identified. The main strategy envisioned by the plan is to mobilize and educate the affected population on the causes and prevention of guinea worm and the provision of potable water in rural communities.

Donors already are supporting programs that can affect the disease. UNICEF has a project to assure potable water and promote health education in villages in the Kara and Central regions. CUSO is providing water pumps in villages and conducting guinea worm eradication in the Maritime region. The Peace Corps and World Neighbors conduct epidemiological surveys and assist with guinea worm eradication in the Bassan district.

Issues for the future

Given that other donors are already engaged in this activity and given that to support it would require USAID to move into new directions, we do not recommend that the mission plan activities in this area. However, USAID should encourage the SNES to incorporate messages on guinea worm in their integrated

H. AIDS

Current Activities

The incidence of AIDS is rapidly growing since the confirmed identification of 2 cases in 1987. There were 15 cases in 1988, 39 cases in 1989 and 15 cases in the first four months of 1990. Confirmed cases probably significantly underestimate the actual cases, given the stigma attached to the disease.

There have been only a few studies of HIV infection. Studies of seropositivity (using only the ELISA test) in blood donors in Lome found a steady rise from 1.85% in 1987 to 2.1% in 1989. A study of pregnant women in Lome in 1988 found 1.5% seropositivity. In neither survey was the sample sufficiently large, nor were the positive cases confirmed by a Western Blot test. The results, therefore, tell us little about prevalence of HIV in the population.

The National AIDS Program follows the WHO GPA strategies and developed a well defined Medium Term Plan in October 1989. The program is based in the Ministry of Public Health with oversight by a multi-institutional Committee for the National AIDS Program headed by a Ministry physician with representatives of most ministries and other government and party organizations. Operational responsibility is managed by a Technical Commission and its Program Bureau.

The program focuses on health education, provision of condoms, protection of the blood supply, surveillance and identification of high risk groups, and epidemiological and operations research. The national program, using national funding has developed and distributed leaflets, conducted health education sessions with high risk populations (prostitutes and prisoners), in all schools, and promoted promotion activities in each prefecture, especially during World AIDS Day. The program has distributed a small number of free

condoms to high risk groups, however, the supplies were inadequate for continued free distribution.

The WHO GPA contributed US\$366,205 in 1989. GTZ provided equipment, technical assistance, and training for HIV diagnosis at the Institut d'Hygiene at Lome and for HIV screening at the Regional Hospital at Dapaong in the Savanes region. It has also provided rapid screening tests for prefectures and some IEC. GTZ has provided US\$635,000 for this activity since 1987. France has supported the Lome Hospital laboratory and equipment for testing.

The Medium Term Plan calls for a three year budget of US\$2.5 million. In addition to providing a variety of short term technical assistance, WHO plans to provide an epidemiologist to assist in the development of the surveillance system for blood donors, pregnant women, patients with STDs, TB patients, and prostitutes. A major effort in IEC will also be initiated with funding from the EEC. GTZ will continue to support laboratories, training and health education. USAID has agreed to provide 1.5 million condoms in 1990 and is encouraging the participation of SOMARC to provide technical assistance in promotion of condom use and cost-recovery. [See Table 10]

In the Ministry of Public Health reorganization plan described in the World Bank Aide Memoire, the National AIDS Program would be part of the Service MST/SIDA in the Division of Epidemiology, although there are indications that the Ministry opposes this transfer.

Issues for Future

The Mid Term Plan lays out a strong program and most donors have defined their roles in the plan. At the present time the central issue to be evaluated is the appropriate means of providing condoms to the program. Condom costs are prohibitive on a massive scale, although free condoms might be provided to high risk groups such as prostitutes at least until their use becomes routine.

Currently USAID is providing 1.5 million condoms and is exploring a means of social marketing of condoms for AIDS. USAID with SOMARC is taking the initiative in this area. Meantime, several other sources of free condoms can provide initial, though severely limited, supplies.

USAID is also considering short term assistance from CDC or centrally funded AIDS projects for the development of the epidemiological surveillance system. This support should be coordinated with the WHO efforts to avoid duplication or conflicting advice.

Any additional USAID participation should probably await the development of better surveillance information so that high risk

groups can be monitored and targeted for IEC activities. Epidemiological surveillance is currently to be supported by WHO GPA and additional USAID support in this area is limited by USAID-GPA agreements. The EEC, with WHO technical assistance will

Table 10

REUNION DE MOBILISATION POUR LE SOUTIEN
AU PROGRAMME NATIONAL DE LUTTE CONTRE LE SIDA AU TOGO
LOME, 30 - 31 JANVIER 1990

Annonce des contributions
(Chiffres en USD)

PARTIES	PREMIERE ANNEE			ANNEES SUIVANTES	GRAND TOTAL
	Par l'O M S	Bilatérales	Total		
CEE *		408.000	408.000	72.000	480.000
PNUD	300.000		300.000		300.000
USAID		55.000	55.000	110.000	165.000
RFA(GTZ**)		234.000	234.000		234.000
UNICEF		33.000	33.000	62.000	95.000
FRANCE***		40.000	40.000		40.000
O. M. S.	350.000		350.000		
FNUAP		à préciser			
IPPF		à préciser			
ISRAEL		à préciser			
ATBEF		à préciser			
Croix Rouge		à préciser			
			1.420.000	244.000	1.664.000

* Contribution de .400.000 faite en ECU ici au taux de 1,2 par rapport au dollar.

** Contribution enregistrée en CFA: soit 70.000.000 F CFA à 300 par dollar.

*** Contribution minimum.

probably dominate the IEC efforts in the medium term, making additional AID activity unnecessary.

While the AIDS program should be monitored and condom marketing should continue to be supported on a limited scale (through SOMARC), USAID should not at this time plan a major project component to address AIDS.

I. Acute Respiratory Infections

Acute respiratory infections constitute the second major reason for consultation for children. In 1989, 122,000 children under five were reported to have consulted health centers for this reason (Statistiques Sanitaires). At the Pediatric services of the University Hospital, pneumonia has been the fourth or fifth cause of death among hospitalized children under 15 every year since 1985 (about 40 deaths per year).

The disease is of concern to the Ministry which has designated it as a priority program in the future. At present, the only activities are the services provided out-patient and in-patient to those who present for care. There are no national protocols for treatment, nor is it likely that sufficient antibiotics are available to undertake such a program. University researchers feel that much work needs to be done before any protocol for acute respiratory disease can be adopted and implemented.

The principal research questions are first, to assess the extent of bacterial, as opposed to viral infections since only the former are treatable; second, to assess which are the most prevalent bacteria in the country and which drugs (antibiotics) would be most effective; third, to assess whether it is feasible and cost-effective to implement a national strategy which would include treatment protocols, availability of antibiotics, establishment of a referral system, and upgrading of equipment for treatment at the referral centers. At present, there is no ongoing research in these areas.

Given the large number of priority programs already under way in Togo (malaria, immunization, diarrheal disease, growth monitoring, family planning, safe motherhood, and AIDS), and given the difficulties some of these programs are still encountering in their early stages of implementation, the launching of yet another priority program does not make sense until the present ones are well established, at least five years hence.

V. CURRENT USAID PORTFOLIO AND RELATIONS TO OTHER DONORS

As discussed in detail above in each appropriate intervention, USAID and Peace Corps health and nutrition activities have played a major role in most Child Survival and Family Planning programs in the country. Here we will review briefly the projects to define their strengths and weaknesses and their relationship to other donor projects.

Health Sector Support for Child Survival Project -- HSSCS

The most problematic project in the USAID portfolio is the Health Sector Support for Child Survival Project. The project components had initial objectives of:

- 1) forming a planning and coordination unit (UPC) to develop planning and budgeting capability in the Ministry of Public Health,
- 2) providing health center support for training health education teams in IEC for community level activities
- 3) encouraging community outreach activity to train community agents and create Village Development Committees (CDV) in two regions (Plateau and Savane)

After two operational years fraught with conflict and inactivity, this project is finally beginning to establish a presence in planning and training activities. It has initiated priority setting seminars for the Ministry of Public Health to set yearly emphases for donor projects. Currently the project is funding an innovative nation-wide training program for village level health education activities. This year the project also plans a series of planning, budgeting and management training seminars for national and prefect level health officials.

The UPC had great difficulty defining its role and gaining counterpart commitment to assume its anticipated role in the planning process. Assigned to the Ministry cabinet, it has been divorced from the operational activities of the Ministry. The initial decision to locate a planning unit above the Directorate General might have had some logic when the ministry was combined with Social Affairs and Women's Condition because there were three Directors General at the time who might have been coordinated by an effective unit at a higher level. However, now that the Ministry has only one Directorate General, it makes more sense to locate a planning unit closer to operations -- either in the office of the Director General or in the proposed Division of Planning and Training anticipated in the Ministry reorganization plan.

The UPC is still marginalized from the major decision-making process, as evidenced by its minor role in the development of the reorganization plans for the World Bank mission. Indeed a sort of implicit competition arose when the planning cell for the World Bank project was established. The other project activities were dependent on the effectiveness of the UPC and have been stymied by its lack of activity until recently.

The objectives of this program in strengthening planning, budgeting and management activities still seems valid and consistent with Ministry of Public Health and other donors, especially the World Bank policy reforms, although the appropriate location of the UPC has not yet been established. Linking operational activities that are not necessarily part of the planning process to the UPC seems to have been an inappropriate approach which neither strengthened the UPC, nor facilitated the implementation of village level activities.

A planning project would better be linked to the operational activities of upgrading and simplifying the Ministry of Public Health and management information system and of assisting in a series of health financing studies and financial system reforms, as we will discuss below.

Combatting Communicable Childhood Diseases -- CCCD

As part of an Africa regional CCCD program implemented with a PASA with CDC/Atlanta, the Togo project has effectively focused on strengthening and expanding the PEV and malaria programs, and has assisted the Statistics Department in a major effort to computerize the epidemiological information system and to improve its quality. With effective technical assistance and training funding, the project has complemented the major funding support for EPI and malaria provided by UNICEF, which should share credit for the success of these interventions.

The project has, however, not developed an appropriate means of strengthening the Ministry of Public Health ORT efforts. The technical officer has not been able to develop an effective working relationship with the unit responsible for LMD.

The project, by strengthening only two interventions, contributes to the vertical nature of project activity in the Ministry, exaggerating rather than reducing the fragmentation of the Ministry of Public Health. A recent failure to take initiatives to coordinate PEV and LMD training with the UPC, is an example of the failure of integration among USAID projects and within the Ministry of Public Health. The training approach even for PEV, with its emphasis on use of high national officials and international consultants as trainers, is also inappropriate for institutional development. It is unreplicable and unsustainable.

CCCD has demonstrated important impacts in effectiveness of two interventions but has been less effective in broad Ministry institutional strengthening. As we note below, a shift in focus toward ORT and nutrition and an incorporation into a single integrated project might help overcome these weaknesses.

Family Planning

The USAID Family Health project has supported both government and private programs in family planning. It provides technical assistance, funding for training and IEC activities, and commodities primarily for ATBEF but also for the PNBEF. Support also is provided through the centrally funded, INTRAH, SEATS and SOMARC projects. SOMARC is developing a program for social marketing of contraceptives.

Population activities in Africa require considerable initial promotion activity and a major national commitment before impact is likely to be demonstrated. Low current levels of contraceptive utilization should not be taken as indications of project failure. HOWEVER, the government program appears to be ready for greater USAID support. USAID should consider reorienting its assistance toward the public sector. Private sector efforts should focus on the social marketing activity.

PL480 Title II Program

This program is implemented through CRS and its Togolese counterparts, the Ministry of Social Affairs and Women's Condition, Ministry of National Education and Caritas/Togo. It manages over US\$3 million in commodities, in three programs: Supplementary Feeding and Nutrition Promotion in the Ministry of Social Affairs Centers for Child Nutrition; School lunch program; and Humanitarian Assistance. The supplementary feeding program accounts for approximately 80% of the project. Monetization of a portion of the wheat shipments has funded operational deficits. Current plans hope to shift responsibility for operations to its counterparts so as to achieve institution-building objectives.

The program is strong in nutrition and health education -- having developed through operations research several important changes in the implementation and supervision of health education programs, and having developed a Guide for Health and Nutrition Education.

The project suffers from failure to target beneficiaries and a lack of integration and referral to health facilities. Consideration of several options for shifting emphasis of the program to health facilities and/or schools are discussed above in Section IV.E.

The Title II program will be evaluated in late 1990 and future activities should be determined in light of that evaluation.

Peace Corps

The Peace Corps has coordinated well with the most effective sub-component of the HSSCS project -- the health center support activity -- and has worked well with two separate ministries -- the Ministry of Social Affairs and Women's Condition and the SNES of the Ministry of Public Health. Peace Corps Volunteers, working with two SNES health education coordinators from each of the 21 prefectures and 9 sub-prefectures have implemented a pilot program of community education in 36 pilot villages. This program focused on village level community organization and health education for EPI, LMD and malaria. Over the first three years, the program included 23 PVC, 60 prefectural coordinators and 5 Regional Agents of SNES. Around 540 village level volunteers were trained and 36 Village Development Committees were formed. This coordinated activity appears to have worked well, however, has raised questions about replicability and sustainability. It is unlikely that all 4,000 villages in Togo could be served by the same intensive model (two trained and salaried health educators in a village).

Current plans for 1990-91 call for a US\$400,000 budget for continuing education training and new sessions to develop regional teams to carry out a cascade training and supervision program and to expand the health education topics to include family planning, nutrition and other interventions. This regional approach, however, might better be considered in the context of a more integrated approach to training, health education and supervision in which all primary health activities are well coordinated at the Prefect level, and under the supervision of a single team of Medical Assistant, Health Educator, and Prefect Nurse.

This project has been one of the few examples of effective coordination among project activities in different Ministries and among different USAID projects. Continued coordination and cooperation between Peace Corps and other health project initiatives should be encouraged.

Coordination with USAID Rural Development Projects

The Rural Development portfolio includes:

- 1) a project with CARE to form credit coops for agricultural producers and small enterprises;
- 2) a Savings and Loan Project with the Togolese Union of Federated Savings and Loan and Cooperatives
- 3) technical assistance of monitoring and evaluation in the Development Fund for Africa

Plans for the future include a new project in environment and natural resource management to assist NGOs promote activities in

these areas.

Very little coordination between health and rural development project activity has occurred. While such coordination is often difficult given the different objectives of the project activities, greater attention to the nutrition impact of Rural Development programs might be established. Nutrition objectives and indicators for agricultural programs have been developed by such coordination in other USAID missions. It might be useful to have nutrition technical assistance to develop targets and indicators for the new environment and natural resource project.

Relation to Other Donors

As in most countries, donors in Togo loosely coordinate their activities through irregular communications and invitations to each others' sponsored activities. There are some areas where coordination in specific programs has occurred rather smoothly -- such as in the EPI and malaria programs where CCCD, UNICEF and WHO appear to work well together. This coordination, however, only increases the Ministry's dependence on foreign support for these activities, albeit multiple sources, are less likely than a single source to be withdrawn all at once.

It seems likely that major donors are all planning to continue support for Child Survival and Family Planning efforts. UNICEF is committed to continuing current project activities in EPI, malaria, and ORT, although some initial steps toward encouraging the government to assume greater financial responsibility for EPI, at least, are envisioned. UNICEF also expects to gain supplementary funding to support village pharmacy programs following the Bamako Initiative objectives. WHO will continue to support the full range of primary health care programs, with perhaps a greater emphasis on AIDS now that the government has established its Medium Term Plan. The GTZ plans to continue its primary health care program in the Central Region, part of which involved Bamako Initiative village pharmacies. It will also continue to support AIDS activities, and the Maternity in Be district of Lomé. A new activity will include funding for facility reconstruction as part of the World Bank initiative. UNFPA will continue supporting the Division of Maternal and Child Health with family planning technical assistance, support for training and IEC, and commodities. The FED will continue to support family planning and has made a major new commitment to IEC for the AIDS Medium Term Plan.

While a rather stable division of labor among the donors appears to have been established, the new kid on the block is the World Bank. Its efforts however have focused on broad policy objectives and institution strengthening. The US\$ 14 million that it expects to commit, has not yet been assigned to any specific activity. Counterpart funding from the current donors is likely to be

complemented by Bank loan funds, rather than replace those grant monies. The Bank estimates a need for US\$ 16 million in counterpart funding for its objectives.

In discussions with World Bank officials, Ministry of Public Health officials, and other donors, there seems plenty of room for continuing USAID current programs and the government reorganization and decentralization plans established for the World Bank loan offer new opportunities for institution strengthening initiatives.

VI. RECOMMENDATIONS

A. Basic Issues

These recommendations concern future USAID project activity in relation to four central issues:

1. Ministry of Public Health Reorganization
 - a. Integration of primary health care activities at all levels, among GOT ministries, and among donors
 - b. Decentralization to the Regional Level
2. Health Financing and Sustainability
3. Technical Areas of Intervention: Child Survival, Nutrition and Family Planning
4. Project Structure for Future AID Health and Population Activities

In this discussion, we will lay out our arguments for different approaches and suggested options. We expect that these suggestions can serve as a guide that can be followed by more specific review in the PID and Project Paper process.

As a first step, we believe that it makes sense for USAID to build on the current four project areas it currently supports -- HSSCS, CCCD, Family Planning, PL480. These projects meet important needs for the country and merit continued support -- although significant change in directions for the activities in each of these areas will be recommended in order to overcome shortcomings and to take advantages of opportunities that are likely to arise from the new initiatives promoted by the World Bank Sector Loan and the Bamako Initiative. We will also recommend consideration of additional interventions within the Child Survival framework.

A major focus of the new project activity should be to strengthen institutional capability to continue the advances that have been made by USAID projects and to begin providing for new local financing options. Both institutional strengthening and increased local financing options should contribute to project sustainability.

We believe that an essential institutional need is the development of a unified management and planning information system that encompasses epidemiological, management, personnel, and financial information. This information system could strengthen the process of reorganization, and contribute to sustainability, while at the same time build on and integrate current USAID project initiatives.

B. Ministry of Public Health Reorganization

Future AID projects will be influenced by the outcome of the current reorganization process that has been initiated in response to the World Bank sector loan proposals. [described in Section II.] Since the final agreement and implementation of this reorganization is currently in flux, here we attempt to develop options that can accommodate different foreseeable outcomes of this process. Our objective is to strengthen such initiatives, but, since these initiatives are not yet clearly defined, we think it necessary to develop project activities that do not necessarily depend on such changes.

The restructuring is expected to place most of the Child Survival activities under a single division -- the Division of Primary Health Care; create a Division of Planning to include the national health information system; and establish regional offices with Regional Directors.

The World Bank plans to provide US\$14 million which is not specifically assigned at the current time. The World Bank support appears to be quite flexible, at least at this point, allowing for cofinancing of approximately US\$16 million by other donors. Other donors have already agreed to provide cofinancing in some specific areas -- for instance GTZ is programming DM 4 to 5 million for facility reconstruction. Since AID is likely to continue to be the largest donor in the sector after the World Bank -- it should be able to define its role fairly clearly over the coming year.

1. Integration

One of the most evident administrative problems in the current organization of the Ministry of Public Health is the lack of integration of program activities. The Ministry operates through separate initiatives in distinct vertical programs that usually respond to donor funded projects. These separate initiatives often result in competing activities, duplication of training, and lack of clear lines of supervision and coordination. Perhaps as important, vertically designed programs discourage the development of appropriate management skills and capabilities at the lower levels of the administrative structure and inhibit rational management at the central level. [see Section II.B]

The new reorganization proposals incorporated in the World Bank Aide-Memoire suggest that the Ministry of Public Health at the central level will become more integrated than its current organization allows. All the Child Survival and Family Planning programs will be united in one division -- the Division of Primary Health Care.

The new reorganization would encourage greater communication and coordination of the national initiatives in PEV, Malaria, ORT, Growth Monitoring and Family Planning -- areas that USAID currently supports with project activities. If, as will be discussed below, USAID future projects will support additional interventions in Maternal Health (or ARI), these also would be integrated in the same division. Since other donors have also focused their funding support in these initiatives, one division will allow the government to coordinate donor programs as well.

How can USAID design its future health and population program so that it might contribute to the effectiveness of this proposed integration?

First, a major project activity that assists the Ministry to create a unified management and planning information system could provide an integrating activity that can encourage greater information sharing, planning and management throughout the Ministry. This activity would build on and combine the initiatives of the UPC in the HSSCS project and the health information system support of the CCCD project. This initiative would require the participation of all major units of the Ministry of Public Health at the central, regional, and local levels in the process of selecting relevant data and designing fewer forms with more selected information. It would also provide a locus for training in the use of data for planning, budgeting, monitoring, and supervision at all levels. By focusing on the needs and uses of an information system the project would allow a more integrated approach and provide an operational rationale for the planning and training activities that have been initiated under the current UPC program. A well designed and decentralized management and planning information system would be useful to officials at all levels -- dispensary, prefectural, regional and national. This activity would serve the whole Ministry and would not be limited to the Division of Primary Health Care -- it would only compound problems of integration to focus an information system only on selected interventions. Nevertheless, it would be a key element that would enforce integration of Child Survival and Family Planning interventions within the Ministry of Public Health.

Second, the USAID program can design its project interventions to encourage their own means of integrating activities within the Division of Primary Health Care. As discussed below, the most logical option would be to unite most of the current projects into one single project.

Third, integration should be encouraged for support as well as intervention activities (e.g. health education should be integrated into all specific disease programs) and out-reach activity (i.e. Agents de Santé Communautaire) should be integrated into the dispensary level.

2. Decentralization

Laudably, the current reorganization proposals call for decentralization of the Ministry of Public Health. As one of the more centralized health systems in Africa, the Ministry of Public Health suffers from a concentration of decision-making authority at the highest levels. This concentration slows decision-making; it leads to inappropriate national policy directives which do not take into account inequalities of resources and needs at the lower levels; it encourages arbitrary decisions in personnel and resource distribution; and it discourages administrators at the lower levels from developing appropriate problem solving management skills.

As a first step in the decentralization process, the reorganization plans of the World Bank Aide-Memoire have given priority to the implementation of regional offices and Regional Directors, positions which had been established in the 1969 administrative reorganization, but never made operational. The proposals also establish a legal framework for decentralization to the health facility level.

While decentralization should be a major priority, it is not clear that regionalization will contribute significantly to this objective -- especially in a country with limited qualified personnel. It is also questionable that regionalization is necessary in a country with only 21 health prefectorals, with easy communication between prefectoral and central offices.

Regional offices can provide a means of coordinating activities among several health prefectorals and a means of coordinating regional health activities with other development programs of regional offices of other ministries (such as Plan, DRDR). However, the current experience with regional offices in other ministries and the limited area of regional authority does not lend itself to significant coordinated activities. It should be noted that an effective regional office could be a significant expense physical facilities, personnel, and logistics and transportation. In economic terms, the costs of creating a regional office might not produce sufficient benefits to justify its implementation.

There would have to be several major changes to allow a regional health office to make a significant contribution to solving health and other development problems:

- a. the regional offices would have to have sufficient personnel with appropriate technical and managerial skills and logistical support to provide support in the principle intervention areas and in administrative and financial systems.

This would mean that a regional office would need several primary health specialists, health education specialists,

management and financial specialists, as well as the Regional Director. These personnel would need appropriate transportation to provide means for supervision and training throughout the region. At minimum such a scheme would require regional teams of 5-6 people in each region with at least two regional vehicles and sufficient gasoline for regular and frequent field activities. It is currently unlikely that sufficient personnel and logistics support could be made available through the national operational budget.

Even if personnel are added to the Ministry of Public Health as anticipated in the World Bank Aide-Memoire, personnel insufficiencies at the lowest facility level - - dispensaries without fully trained nurses and midwives -- or at the prefectural level -- an administrator or trainer/supervisor -- should be given priority.

- b. the regional administrative level would have to have budgetary and personnel authority to make autonomous decisions over significant funds and personnel actions.

Unless some kind of block grant from central funds to the regions is made available, it is unlikely that the regional level will be able to make significant enough decisions to justify the cost of putting regional teams in place. The current system does not allow the médecin-chef control over significant budgetary resources.

An attractive advantage of regional offices is that they provide a means of coordinating among several prefectorals. This coordination, however, might be achieved with less cost by centrally mandated regular coordinating meetings (ie. monthly) in which médecins-chefs meet to coordinate activities and file routine reports to the central level.

Regional offices have a great potential to be either ignored -- because they have insufficient skills, financial resources, and/or authority -- or to become an additional bureaucratic layer that poses more obstacles and slows communication and approval processes between the periphery and central offices.

It is likely, however, that the regional offices will be created by the reorganization plan. This gives USAID two major options:

- 1) support the regionalization process with significant funding that will make possible the placement of strong, skilled regional teams with adequate transport capability and with enhanced budgetary and administrative authority. [1 and 2 above]
- 2) develop decentralized capability at the prefectural level

in ways that are compatible with and complementary to the eventual implementation of the regionalization plan.

We suggest that the second option is more likely to be an effective and cost-effective program and one that can build on USAID's current strengths in the area. A focus of resources and capabilities at the prefectural level might also complement the central level integration approach described above, by providing the appropriate locus for information systems and management decision-making and problem-solving. This approach also allows the USAID program to proceed without awaiting the outcome of the reorganization being negotiated with the World Bank.

Focus on the Prefectural level

As described above, the médecin-chef is the key link in the health system and one that has often attracted capable officials. This level is crucial for supervising and training personnel in the prefectural health centers and dispensaries.

It is at this level that additional resources for transportation would be most effective. As noted above in Section II.B. the lack of sufficient transportation for supervision is a key weakness of the current system. Additional resources might be provided on a declining basis if the World Bank loan agreement effectively provides phased additional national resources to the health sector.

In addition, the development of management and financial capabilities of the district level would strengthen responsiveness of the health system to the different epidemiological situations and unequal resources available at the local levels. A management and financial information system at this level (and provided by information feedback from the national level) can contribute to developing management and planning capability. A management and planning information project component could be designed around the provision of appropriate data for prefectural management. It should be designed to include training modules with exercises in utilizing the prefect level data to identify problems, develop solutions and monitor and evaluate those interventions. For instance, limited supplies of medicine could be more rationally distributed among dispensaries if the population size of catchment areas, consultation demand, monthly case patterns and current drug utilization data were routinely available to the médecin-chef.

The above activities would strengthen local level activities, regardless of whether or not the anticipated reorganization occurs. However, if it does, the management and planning information system could provide an essential tool at the district level for more informed decision-making for personnel distribution, incentives, and sanctions. Currently, the médecin-chef must have approval from the Ministry Cabinet to take even the most minor personnel actions. While there must be some control to prevent potential abuses at the

lowest level, management flexibility in personnel location, leaves, and advancement would give the medecin-chef a significant management tool to place personnel in the most appropriate locations, to judge performance and to provide rewards and sanctions to improve quality of services. This capability is tied to adequate management information at this level, supervisory observations, and the devolution of personnel decision-making authority to this level.

Supervision at the Prefectoral level

The medecin-chef is the lowest level supervisor responsible for the effective delivery of service by the Medical Assistants, Nurse-Midwives, Chief Nurses, Midwives and Auxiliaries. A major weakness of the Ministry is the lack of an effective and systematic supervision policy. While the medecin-chef is supposed to be responsible for supervision, he seldom has sufficient time or transport to visit health facilities frequently. There are no standard forms or schedules of supervision (except for immunization activities). Nor is there sufficient training in the essential skills that make for effective supervision.

Appropriate management information at the prefectoral level can assist the development of a more effective system of supervision. It can provide the important indicators for problem identification and solution development. Comparative data with other facilities might also provide motivation for improved services.

Several issues about supervision should also be addressed. The current role of the medecin-chef requires significant time devoted to curative consultations. It is unlikely that any trained physician in this position can avoid such responsibilities since he is often the only physician in the prefecture. Rather than design a supervision program that requires greater time from the medecin-chef, the creation of supervisory teams -- including the medical assistant, the health education coordinator, and one of the more experienced nurses (a nurse supervisor) -- might be considered. A new project might assist the Ministry develop a national supervision policy which provides training for such a team, logistical support, and regular check lists and reporting forms.

Census and Demographic Health Survey II

The government currently plans to initiate a 1991 census, and USAID has committed itself to supporting this effort. In addition, a second Demographic Health Survey is planned to provide longitudinal trend data since the 1988 survey. We support both these efforts because improvement of demographic data from both sources will assist in management and planning activities.

C. Financing and Sustainability

Current financing of the health sector may be significantly changed by the World Bank Loan agreements. If the negotiations in July provide an agreement that is anticipated by the Aide-Memoire, increased national budgetary sources will be available for the health sector. The current targets are to increase the proportion of the national budget devoted to health by 6 to 8 %. It will also encourage the decentralization of control of the budget to regional and prefectural levels. Finally, it anticipates greater attention to cost-recovery and self-financing, including expansion of the private sector. UNICEF's Bamako Initiative also encourages self-financing, mainly through the development of village pharmacies for essential drugs.

Future USAID project(s) could buttress the World Bank Loan and Bamako Initiative in a variety of ways.

- a. reinforcing the policy conditions of the World Bank Loan. USAID might place conditions precedent for new projects to encourage the Government to adopt appropriate legislation and regulations to encourage decentralization and reorganization. In particular, USAID should use conditions precedent to encourage the government to support:
 - 1) increases in the national budget allocated to health, .
 - 2) budgetary autonomy at the regional and prefectural levels.
 - 3) efforts to allow retention of fees at the health facility that collects them -- an essential change if management incentives for improved quality and cost savings are to be effective.
 - 4) increases in non-personnel recurrent expenditures
- b. supporting a variety of economic and financing studies -- perhaps through buy-ins to centrally funded projects -- to monitor funding levels and the distribution of funds within the Ministry of Public Health and to determine beneficiaries demand and willingness to pay.
- c. providing technical assistance for the development of appropriate accounting and auditing mechanisms -- especially at the prefectural level.
- d. supporting studies of the current level of private practice - including traditional midwives. These studies should explore potential for shifting the burden of curative care to the private sector so that more public resources can be devoted to primary health care. They should also evaluate potential for regulating the private sector to assure quality

-- especially for immunizations.

D. Child Survival Interventions and Health Information

We think that the current Child Survival areas that have been the focus of the current HSSCS, CCCD and Family Planning projects should be continued as the major activities of new project programs. Our concern is that they be much better integrated into the Ministry of Public Health.

We propose a reorientation of these activities so that they focus technical assistance, training and logistical support on integrating activities in the Maternal and Child Health Division. This would mean several changes in current programs.

Reorient the CCCD activities

The interventions of the CCCD project should be shifted from their current focus on PEV and malaria to a greater emphasis on diarrheal diseases and nutrition. PEV and malaria have received significant support from both CCCD and UNICEF and we agree with UNICEF that it is now time to consider phasing down this support and encouraging the government to assume greater responsibility for sustaining it. This phased withdrawal of funds for these two interventions should occur over the life of the project.

Studies of sustainability reiterate the importance of shifting budgetary support from donors to the government during the life of the project. The Ministry should be encouraged to shift resources out of curative expenditures toward these priority areas to decrease the dependency ratio of the essential and successful programs. Ministry budgetary priorities should reflect the stated priorities of the national policy.

The phased withdrawal of CCCD and UNICEF funding for PEV and malaria should not mean an undermining of the programs. The PEV is now well developed and the continuing education training activities necessary to maintain quality should be integrated into other training activities of the Division of Maternal and Child Health. Greater emphasis on the routine and AVT program should replace the costly mobile units. CCCD technical assistance and its support for vaccines should be gradually reduced so that the government is encouraged to increase its budgetary support for this program.

Similarly the chloroquine supplies for the malaria program should also be gradually reduced over the life of the next project, with the government encouraged to shift its budget toward covering these costs. However, the malaria program is still in need of monitoring and technical studies, especially in vitro testing. CDC/Atlanta has expressed interest in continuing studies of malaria and using

these studies to establish more appropriate policies for this difficult disease. Some support for continuing research should be provided in the next project.

The diarrheal disease component has not fared as well PEV and malaria. In order to strengthen this program and to encourage its integration with other MCH and nutrition activities, it would be appropriate to locate CCCD technical assistance in the Division of Maternal and Child Health and to concentrate an increasing level of funding on these efforts.

It is important to emphasize that we think the intervention orientation has its limits and that the vertical approach should be avoided. This reorientation of CCCD activities should emphasize institutional strengthening and integration of program activities in Maternal and Child Health. The diarrhea control intervention should simply be a focus which orients some of the activity. The primary effort should be to use these resources to strengthen overall skills and delivery of integrated maternal and child health activity. Technical assistance should be located in the Maternal and Child Health Division and, through the mechanism of a single project, this project sub-component should be coordinated with the management and planning information system and family planning.

HSSCS and Peace Corps: Health Education and Community Outreach

The combined health education activity of HSSCS project, the Peace Corps and SNES appears to have been particularly effective in the concentrated pilot villages. The current expansion of these efforts into a cascade training program for prefectural health education teams, zonal teams and village outreach might provide an effective model for future project activities. The impact of this recent initiative should be evaluated over the coming year.

Again, it is important to continue this activity, but to orient it toward greater integration of Child Survival and family planning activities. Currently health education activities tend to focus on only one or two interventions. This approach might be necessary for initial exposure -- so that single themes are more easily packaged and understood by both health educators and by the mothers. However, many of the health education activities could be combined in training sessions, and in programs of health and nutrition talks at health facilities. The effective approach to health education that has emerged from the CNI program of the Ministry of Social Affairs and CRS, could be used as a potential model. Its recent Guide for Health and Nutrition Education treats the principal interventions in one single guide.

This component should build on the relatively effective coordination of the National Health Education Service (SNES), the Ministry of Social Affairs and Women's Condition, and Peace Corps. It would be useful to consider providing technical assistance

directly to SNES in order to strengthen the skills of this institution in the development and implementation of IEC activities. These activities should also be coordinated with the Division of Maternal and Child Health.

Family Planning

The current project has supported ATBEF's assistance to public sector activities. ATBEF provides training and distributes contraceptives to the public sector. While this approach may make sense in initial stages of promotion of family planning, it is now appropriate to begin shifting responsibility for this training and distribution and to fully integrate it into the Ministry's public program.

Since there is a UNFPA consultant providing long-term technical assistance, USAID funding should complement this technical assistance with funding support for training and IEC activities, as well as contraceptive supplies. On a short-term basis, technical assistance from the regional offices of centrally funded projects (SEATS, INTRAH, and SOMARC) could support specific project needs in most areas.

Support for ATBEF should shift from its current emphasis on training and distribution for the public sector to a greater orientation on private sector activity -- especially social marketing. Use of SOMARC in this area will continue to be appropriate.

Supplementary Feeding

As noted above in Section IV.E. and Section V. there are several options that might be considered for reorienting the PL480 Title II Program. We feel, however that decisions about the future role of this program should await the full scale evaluation planned for later 1990.

Other Interventions

We have reviewed other potential interventions for future USAID activities: AIDS, dracunculosis, and ARI. As documented in Section V. many other donors are providing support for the Medium Term Plan on AIDS and there does not at this time seem to be reason for a major USAID project activity in this area. The situation for dracunculosis is similar, with potential support coming from Global 2000, FED and UNICEF.

While ARI is a major problem that could be addressed in an integrated project, there is insufficient guidance in the international community on the best approach to follow in this intervention. We feel that it would be better to focus on the current child survival activities than to attempt to initiate a new

program without a clear idea of the appropriate strategy. With our interest in improving the integration of current interventions, we think adding new initiatives would only disperse efforts and could undermine attempts at integration.

E. Future Project Design

We think that a Sector Program approach should not be followed. We favor the design of a single project that integrates the three current Child Survival and Family Planning projects and reorients them to respond to institutional strengthening and sustainability objectives. However, we offer several cautions about this approach. We feel that the appropriate approach to the PL480 feeding programs might consider some innovative options, but should best be developed after a full evaluation of the project in late 1990.

1. Sector vs. Project Approach

We understand the differences between sector and project approach to be:

- a. the sector program approach places emphasis on providing funds to the national budget to assist the government to achieve specific target indicators -- largely at the policy level. The grant would be in several tranches allowing for withholding of funds until target indicators have been met. Funds could be provided for technical assistance, however, they would not be tied to specific project activities.
- b. the project approach focuses more specifically on selected activities and ties funding and technical assistance to those activities. These activities may have target objectives but failure to meet those objectives would not necessarily result in suspension of funding.

Since the World Bank Loan follows a sector approach we think it prudent for USAID to provide more specific project funding and technical assistance to support activities that will help the GOT achieve the targets of the World Bank sector loan. The World Bank objectives for the sector loan are compatible with USAID objectives for institutional strengthening and cost-recovery, and they encourage funding in Child Survival areas. If USAID followed a similar sector approach it would only modestly change these objectives.

Since the GOT is likely to make a commitment to the sector policy objectives of the World Bank loan, it is unnecessary for USAID to use a sector loan for policy dialogue. The dialogue is occurring and the government will make its commitments through the World Bank

process.

It is our feeling that additional resources to obtain basically the same objectives would best be placed in targeted specific activities that will be necessary for the GOT to achieve those objectives.

2. Single Project

The current health and population portfolio includes four separate projects: the Health Sector Strengthening Child Survival Project; Combatting Communicable Childhood Diseases; Family Planning; PL480. This multiple project activity has had some clear disadvantages. Perhaps most important, it does not encourage integration of the separate initiatives; rather it further contributes to the fragmentation of the GOT health activities into vertical project activities. In addition, it places a significant management burden on the USAID office.

The major reason for combining project activities into one project is to provide an additional mechanism for integrating primary health care activities. While the project will have sub-components, it will also have a management communication structure, including a routine reporting and management meetings, that would encourage compatible scheduling and combined activities. This mechanism could provide means to share knowledge of activities within the Ministry of Public Health and among the Ministry of Public Health, the Ministry of Social Affairs and Women's Condition, ATBEF, etc.

A single project would be designed to incorporate three of the current projects into one single project that would be managed by a contractor. This contractor would be responsible for all sub-components although it might sub-contract different sub-components to other contractors or in the case of CCCD activity, might be responsible for coordinating PASA activity. This contracting mechanism would shift some of the administrative burden of the USAID office to the contractor and provide more financial flexibility and responsiveness.

There are, nevertheless, several cautions to consider in the creation of a single project.

Perhaps most important is the difficulty of placing the project in an effective location in the Ministry of Public Health administrative structure and selecting the appropriate national counterpart for the project. Many projects fail because of poor location or an inappropriate counterpart director. With several projects the risk of blockage is spread, while a single large project can be severely constrained with inappropriate location or key personnel.

A single project that combines management and planning information systems, Child Survival and family planning interventions, and health education should best be located at the Director General level or in the Division of Planning. This location provides the operational focus necessary for all activities. The experience of the HSSCS suggests that attachment to the Ministry Cabinet is not sufficiently operational to be in the appropriate information flows and authority lines to have a clear role in program operations.

The arrangements for counterpart should consider several options. If the location of the project is in the Directorate General or Division of Planning, the Director General or the Director of the Division of Planning might be selected as counterpart director of the project. However, in Togo, the experience of having a counterpart director of the UPC with too many other responsibilities suggests that this arrangement can inhibit project implementation. If the new project follows this counterpart design, since the DG or Director of Planning would have many other responsibilities, it might be useful to have another national counterpart to act on his behalf for routine project activities. In other countries co-directors (one national and one international) act under the direction of the Director of Planning or Director General.

The second area of concern is how contracting can be arranged if the project is to include CCCD. It is not clear how contracting arrangements can be made between a PASA and a private contractor. The USAID office should explore this issue in light of potential changes in the CCCD regional project. The problems of coordination among CDC/Atlanta; USAID/Washington; USAID/Lomé might be complicated by having a contractor as an additional intermediary. There may be legal constraints on a PASA that would prevent its subordination to a private prime contractor. It is clear, however, that a project subcomponent in Child Survival interventions can be designed to follow on the current CCCD activity, without necessarily using a PASA with CDC as the implementing mechanism. Many private consulting firms have similar expertise and experience in implementing such components. Nevertheless, CCCD has built up an excellent reputation and considerable good will in Togo and continuation of CDC involvement could build on that positive base.

3. Proposed Project Design

We propose a single project with three sub-components:

a. Management and Planning Information System Support

This sub-component would involve a redesign of the HSSCS activity to focus on the development and utilization of a unified and decentralized management information system that can form the basis for integration of activities, management, planning and supervision, especially at the prefectorial

service delivery level. Technical assistance should be provided for both the information system design and for utilization of that system for management decision-making and for planning. Support for workshops, field testing, and operations research at all levels to achieve appropriately designed system and simplified forms will also be necessary. Finally, a series of training sessions in data use for management and planning should be supported to develop skills in problem identification and problem solving.

This subcomponent would also include development of integrated financial systems and health financing studies. Technical assistance in health economics and financial systems could be provided either by a long term consultant or by buy-ins to centrally funded health financing projects. Perhaps a subcontract with a local or regional accounting firm could assist in the development of appropriate control systems in a decentralized budgetary system.

Support for the 1991 Census and the second Demographic and Health Survey should also be included in this component.

b. Child Survival and Nutrition Interventions and Health Education

This sub-component would reorient the CCCD program gradually to phase out of the already effective PEV program and reduce malaria support to focus on surveillance and research. This sub-component then would be designed to give greater emphasis on control of diarrheal diseases, nutrition and maternal and child health, currently the weaker programs in Child Survival. While CCCD has a good relationship established in the country, it is not clear what the future regional project will look like. USAID should plan its program not to depend on CCCD, but rather to allow its incorporation if possible. A realistic alternative is to use other consulting firms with experience in Child Survival projects.

This sub-component would also contribute to the management and planning information system and integrate its activities, along with those of Family planning into the broader Maternal and Family Health program.

Building on the effective health education program of HSSCS, Peace Corps, and the National Health Education Service, this sub-component would continue to support health education activities and encourage integration of health education in all interventions. IEC technical assistance to SNES should be provided.

c. Family Planning

The orientation of this sub-component would be to expand support for the public sector program and strengthen its integration into the management information system and the activities of the maternal and child health program. USAID support for ATBEF would shift its emphasis toward social marketing activities. While there is no need for long term family planning technical assistance -- since UNFPA is providing a long term consultant to the Maternal and Child Health Division -- greater efforts to enlist greater centrally funded buy-in technical assistance from regional offices of SEATS, INTRAH, and INTRA could be useful.

At the present time, sufficient activity and donor support is being given to activities for AIDS, dracunculosis, and ARI. Given limited absorptive capacity in the Ministry of Public Health and the comparative advantage of continuing to build on previous program strengths, no major sub-component activity should be designed in these areas.

The future of PL480 Title II project should be determined after a full evaluation, scheduled in late 1990, is completed.

This single project, with its central emphasis on integration and decentralization through development of a management and planning information system, would provide focused support for obtaining broader sectoral objectives of the Ministry reorganization envisioned as part of the Health and Population Sector Loan from the World Bank. The financing sub-component could support the decentralization and cost-recovery objectives of both the World Bank Loan and the Bamako Initiative. The Child Survival and Family Planning components would continue the complementary efforts of USAID, UNICEF, UNFPA, WHO, and other major donors.

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