

PD-AAH-239  
CLASSIFICATION

683-0214  
001501  
Report Symbol U-447

PROJECT EVALUATION SUMMARY (PES) - PART I

1. PROJECT TITLE Basic Health Care Delivery Services (AFRICARE - OPG)			2. PROJECT NUMBER 683-0214	AID/AFR-G - 1271
5. KEY PROJECT IMPLEMENTATION DATES			4. EVALUATION NUMBER (Enter the number maintained by the reporting unit e.g., Country or AID/W Administrative Code, Fiscal Year, Serial No. beginning with No. 1 each FY) 80-3	
A. First PRO-AG or Equivalent FY <u>77</u>	B. Final Obligation Expected FY <u>79</u>	C. Final Input Delivery FY <u>81</u>	<input type="checkbox"/> REGULAR EVALUATION <input checked="" type="checkbox"/> SPECIAL EVALUATION 6. ESTIMATED PROJECT FUNDING A. Total \$ _____ B. U.S. \$ <u>2.8</u> million	
			7. PERIOD COVERED BY EVALUATION From (month/yr.) <u>Sept. 1977</u> To (month/yr.) <u>August 1980</u> Date of Evaluation Review <u>9/1980</u>	

8. ACTION DECISIONS APPROVED BY MISSION OR AID/W OFFICE DIRECTOR

A. List decisions and/or unresolved issues; cite those items needing further study. (NOTE: Mention decisions which anticipate AID/W or regional office action should specify type of document, e.g., airgram, SPAR, PIQ, which will present detailed request.)	B. NAME OF OFFICER RESPONSIBLE FOR ACTION	C. DATE ACTION TO BE COMPLETED
1. Amend Grant Agreement and PIO/T to extend the PACD until March 31, 1981 (six month extension with no additional funding required.)	Huffman AFR/DR/SFWAP	Nov. 1980
2. The following positions are recommended for inclusion in the technical assistance component of the Rural Health Improvement Project (683-0208):  Public Health Physician Auto Mechanic Epidemiologist Administrative Assistant Secretary Project Coordinator (WASH DC based at half time salary)	JJohnson JMcEnaney MGolden	Dec. 1, 1980
3. Complete Evaluation Protocol for RHIP (683-0208) based on experience of this evaluation.	M. Baker	Nov. 1, 1980

9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS

<input type="checkbox"/> Project Paper	<input type="checkbox"/> Implementation Plan e.g., CPI Network	<input type="checkbox"/> Other (Specify) _____
<input type="checkbox"/> Financial Plan	<input checked="" type="checkbox"/> PIO/T	_____
<input type="checkbox"/> Logical Framework	<input type="checkbox"/> 638-214-70834 PIO/C	<input type="checkbox"/> Other (Specify) _____
<input checked="" type="checkbox"/> Project Agreement	<input type="checkbox"/> PIO/P	_____

AID/AFR - G 1271

10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT

A.  Continue Project Without Change

B.  Change Project Design and/or  Change Implementation Plan (Extend PACD date)

C.  Discontinue Project

11. PROJECT OFFICER AND HOST COUNTRY OR OTHER RANKING PARTICIPANTS AS APPROPRIATE (Names and Titles)

*[Signature]* Baker, PDE, USAID/Niger

12. Mission/AID/W Office Director Approval

Signature *[Signature]*

Typed Name Jay P. Johnson, USAID/Niger

Date September 19, 1980

## Preface

The Mission has chosen to add several comments to the evaluation report completed by the evaluation team for this project. Our primary intention is to provide additional information - at least from the Mission's perspective - on the implementation of this project which we believe is critical.

Throughout the design and implementation of this project, it appears that there was and continues to be some fundamental difference in the anticipated results of the project among the host country, AID and AFRICARE. The initial design of the project was undertaken in the early 1970's in Niger. Earlier project design documents clearly show an emphasis on Public Health Administration concerns and specifically on strengthening the provision of primary health care to rural villages. The technical assistance components of the earlier proposals do not include individuals to provide direct curative medical services but contain a number of public health specialists to work in areas such as curricula development, health education, and sanitation. Changes in project inputs made during 1976 reflect new directives of the Government when AFRICARE was negotiating the project agreement with the host government. As a consequence, the January 1977 project document retained essentially the same objectives as earlier documents but also a modified (and less appropriate) set of inputs to be used in achieving such objectives. It is not clear from available documentation why AFRICARE did not revise its project objectives more extensively than it did in light of the modified set of inputs. Thus at the outset of the project AFRICARE seemed to be locked into an agreement with AID on a set of project objectives and with the GON on a set of project inputs. This set of circumstances, in the opinion of the Mission, led to the mixed results shown in the attached project evaluation.

With respect to project evaluation methodologies, the Mission normally allows the project evaluator a free hand in determining evaluation methods and formats. The evaluator, in this case, chose to base the evaluation on the document entitled "Implementation Design and Preliminary Planning Data" dated January 31, 1977 and to use the standard format for PES Part II. In retrospect it may have been preferable for the evaluator and the concerned parties to re-define the basic objectives of the project (primarily purpose and output). Redefining the project purpose and outputs in light of actual project implementation always incurs the risk of losing some of the objectivity of the evaluation. On the other hand, evaluating the project according to ill-defined and overly ambitious objectives equally does little in assessing the actual benefits received from the project and realistic progress to date.

In the evaluation, the project outputs as defined in the project document were poorly conceived and consequently rendered it very difficult to clearly define areas where progress was achieved. The outputs specified in the project documentation (1/77) reflect AID's public health concerns more than GON concerns to provide curative medical services. Evaluating the project according to those outputs specified in the above noted document emphasize the rather mediocre performance of the project in respect to its public health objectives and perhaps unfairly deemphasizes the rather outstanding performance of the two doctors stationed at the Diffa hospital who provided high quality medical services during the project.

With respect to the project purpose, the evaluation team's findings conclude that this purpose has generally been accomplished, especially in the Diffa Department where the project has developed and operated an effective logistical and supply system. Secondly by providing direct medical services, the curative aspects of the department health delivery system have been, during the life of the project, considerably strengthened.

In the Mission's opinion the conclusions drawn by the evaluation team are correct particularly in respect to the project directly providing badly needed services (both medical and support services). It is very obvious that during the life of the project, both the quantity and quality of health services provided in the Diffa Department markedly increased. One may query however as to the residual aspects of the project and the ability of the GON to continue to level of health care provided as well as coverage. Progress toward institutionalizing the project purpose has been far less significant, although to a large extent outside the control of AFRICARE personnel assigned to implement the project.

Finally in addition to the helpful suggestions contained in the evaluation report as lessons learned, the Mission would add:

1. In projects where the expectations of the involved parties differ in respect to basic aspirations, project management problems should be anticipated and measures taken so that these differences can be negotiated and resolved in a mutually acceptable manner. AFRICARE should have anticipated implementation difficulties after being requested to reconsider its planned inputs in 1976 and accordingly should have strengthened its in-country management capability to forcefully and expediently deal with implementation issues as they arose. Periodical evaluations by AFRICARE or disinterested persons would also have permitted AFRICARE to modify the project in light of the actual implementation experience.
2. Throughout this project, AFRICARE has shown itself capable of recruiting highly qualified and dedicated technicians to implement their project. As an organization, they have performed less well in providing adequate project direction and coordination which would have permitted the team to function as a team. Project direction was critical, especially to this project which was physically located at one extreme end of the country and which contained some rather diverse activities.

3. Clearly the quantity of human resources available to the MOH is inadequate for it to implement the national health programs for which it accurately perceived the need and is trying to implement. The Ministry is also presently trying to reduce its dependence on expatriate advisors especially those dealing in basically management and policy related areas. The Ministry should realize that given its lack of manpower, it faces a rather cruel choice of retrenching somewhat on its national health program (primary, secondary and tertiary) or relying to a greater extent on expatriate technicians.

Evaluation Report of the Principle Evaluator.

13. Summary of Current Project Situation

The AFRICARE Implementation Design outline of January 31, 1977 is the document used in this evaluation.

The AFRICARE/Diffa project began in 1977. Its principle objective is to strengthen the existing health care delivery services of the Ministry of Health within the Diffa Department. This was to be achieved through training Nigeriens and developing a functioning logistic system. The project was planned to be operational at two distinct levels. At the national level, a nationwide epidemiological surveillance unit would be developed and Nigeriens trained to staff and direct it. At this level, assistance was also planned to assist the national laboratory develop standardized testing. At the department level, AFRICARE would assist the development of departmentwide health delivery systems through training and retraining Diffa-based state nurses, certified nurses, midwives and village health workers. The project would also strengthen the logistical infrastructure through construction of a department office building, vehicle repair and maintenance garage and development of an equipment maintenance shop.

To effect these objectives, AFRICARE provided six technicians, two of whom (public health doctor and epidemiologist) were assigned to Niamey to work primarily at the national level aspects of the project.

The epidemiologist was assigned by the Ministry of Health to assist in the development of standardized testing at the national laboratory in Niamey. The public health physician was to increase and strengthen the public health course content in the curriculum of the state nurse training school in Niamey, Ecole Nationale de Santé Publique (ENSP), and the certified nursing school in Zinder, Ecole Nationale d'Infirmiers Certifiés et d'Aides Assistants de l'Action Sociale (ENICAS). Additionally, he would promote and assist in retraining of the health personnel in Diffa, and act as liaison for the AFRICARE personnel posted in Diffa. The Ministry of Health assigned the public health physician to an advisory role within the Ministry of Health in Niamey for activities of the AFRICARE project in Diffa and in public health matters generally.

In Diffa, AFRICARE placed four advisors, a garage mechanic, a biomedical equipment technician, a gynecologist and a surgeon. The latter two advisors would train Nigerien doctors and state/certified nurses. The former two would train Nigeriens to a level where their activities could be assumed by Nigerien personnel within the three-year period. Apart from the certified nurses, who spend ten months of their formal training program rotating through a department hospital, no systematic training of Nigeriens has been effected as a result of this project. It appears that NO training plan had been developed by AFRICARE or the Ministry of Health.

Although the project was funded from 1977, no program activities were actually initiated in Diffa until 1978. This was due in part to the fact that the AFRICARE/Diffa personnel were being recruited or awaiting completion of building construction. The epidemiologist and public health physician arrived in March 1977, later followed by the mechanic and equipment repairman. The latter two were assigned temporarily to the Niamey Department. Also, concerning the training of additional village health workers, the planting season was just beginning which precluded such training until the end of 1977, after the harvest season. Therefore, for all practical purposes, and according to the Departmental Director of Health for the Diffa Department (DDS), the project has only been in operation for just over two years.

The government unequivocally sees the project as one directly providing health services to the population of the Diffa Department. Given this perspective, the AFRICARE project has been received positively both at the national and department levels. The government's expectation is that these services will continue irrespective of whether or not specifically by or through AFRICARE. AFRICARE personnel have been exceptionally well-qualified and have provided direct services in a dedicated and professional manner.

With respect to AFRICARE's adhering to the January, 1977 Implementation Design, in our judgement AFRICARE has performed modestly well given the very ambitious targets and time frame noted in the design. AFRICARE directed its efforts in accordance with the strengths of its personnel. For instance, the project requested an epidemiologist primarily to assist in strengthening the MOH surveillance unit. The first candidate had a strong laboratory background and devoted his time primarily to strengthening the national laboratory in Niamey and the development of standardized laboratory techniques. While the team was unable to verify results of this effort, it should be noted that the epidemiologist was cited on several occasions for his exemplary work during a meningitis outbreak and an investigation of food poisoning in 1978. However, this activity had no direct impact on the improvement of laboratory techniques in Diffa, which today remain deficient and inadequate. The second epidemiologist, having a statistical background, avoided the national laboratory and worked in the surveillance unit of the Ministry of Health. Although only with the project for seventeen months, it is evident that he was effective and contributed significantly to the development and direction of this national unit. Within the Diffa Department, however, the evaluation team did not observe any systematic data collection efforts which contributed significantly to the day to day monitoring of this project.

At the Diffa level, AFRICARE had no full-time direct public health input into the project. The departmental public health activities have been directed by a Nigerian departmental director who was injured in an accident some eighteen months ago and has been unable to devote full time to departmental activities. Some assistance has been provided in public health matters by a French MD who divides his time between assisting in supervising the village health team program, conducting "Protection Maternelle et Infantile (PMI)" sessions and conducting rounds at the Diffa Hospital. In 1979, a Nigerian state nurse with public health training was assigned full-time to supervise the activities of the village health team program. This input has enabled public health functions such as program planning, budget preparation, drug supply monitoring and supervisory visits to receive the attention they need and have not been receiving.

In contrast to the original purposes of this project expected by AID to strengthen and expand the existing health care system through providing on-the-job-training, AFRICARE found itself the provider of direct services in Diffa. The garage mechanic, in developing and augmenting a vehicle maintenance service to assure continued supply networks and program supervision, has not been able to develop a trained cadre of Nigeriens to take over and continue this component. Not only does he generally do most of the repair and maintenance work on project vehicles, but maintains all

Ministry of Health vehicles in the department. The gynecologist and surgeon have had no medical students assigned to them for training, and have provided no training to state nurses from ENSP, the majority of whom will be assigned to work in a hospital. The gynecologist and surgeon have been involved in the training of certified nurses, matrones and midwives. The training of certified nurses was routine as part of the nurses' formal training and midwives and matrones were trained or retrained in several activities but this has not been systematic. None of the six AFRICARE personnel had a designated Nigerian counterpart for whom the technician could have provided invaluable training. As a result, the training of counterpart staff as a critical component of this project mutated to providing direct services.

Concerning the training of village health workers (VHWs), the Government of Niger had initiated such a program in 1964 which AFRICARE was asked to strengthen and augment. In Diffa, this meant financing locally developed VHW training programs in addition to certified and state nurse supervisory visits to these personnel. Four times a year the public health physician in Niamey would visit Diffa, a two-day trip from Niamey, to monitor progress in the village health team program. The AFRICARE staff in Diffa had nothing to do with securiste training. The public health physician could assist in the training program by either helping to develop the ten-day curriculum or actually participating in the training. Often the inability to speak the local language precluded him from

direct communications in these instances. The public health physician was forced to work through an interpreter. This, of course, is not unique to this particular project but holds true for most foreign technical assistance.

As an infrastructure support project, AFRICARE played a dual role. On one hand, through the development of a functioning vehicle repair system a direct contribution was made to the mobility of the program. This mobility in turn allowed greater access to the VHW by the CM and dispensary nurses, i.e. improved supervision. An assumption of this project is that health services will continue to be provided to villagers as long as supervisory visits to the village health teams (VHTs) are conducted on a systematic basis. How those VHT services are provided and the improvement of the provision (delivery) of VHT services and the services themselves are not the focus of this project. However, AFRICARE was expected to play a part in the development of a plan for carrying out supervisory visits. AFRICARE assured that vehicles were in a functioning state to enable such visits to be conducted. However, it was the DDS and his assistant that developed a plan for systematic supervisory visits. In spite of this, in 1978 no supervisory visits were performed. In 1979,

only about two or three supervisory visits were performed by each Circonscription Medicale (CM)<sup>1</sup>. Since January the situation has improved. Although we do not have quantifiable information to attest to this, we were assured by the DDS and heads of the CMs that the latter were getting out on supervisory visits every other month. The dispensary nurses appeared to be making efforts to undertake visits monthly. However, occasionally this was not possible due to vehicules being down or horses not available. These supervisory visits were financed by AFRICARE.

There are no records of what was done by whom on supervisory visits other than the strict accounting of gasoline consumption. It should be noted that the evaluation team regards supervision of the project as a key factor in the success of the project. It is regrettable that: a) no data concerning the number of visits, b) observations on how personnel in the program were performing and c) especially no data which would provide some feedback as to the performance of the VHW were gathered by the project. Several other departments (notably Maradi, Dosso and Niamey) have

<sup>1</sup> Diffa Department, Annual Report, 1979, p. 28. The AFRICARE Representative disputes this point. He noted in a meeting on 7/5 that they received bills from Diffa to pay for fuel used in making supervisory visits. Apart from this, AFRICARE has no records of the number of supervisory visits made in Diffa by department personnel. We left it to the AFRICARE Representative to bring this disagreement to the attention of the Diffa DDS for a resolution.

initiated the collection of public health statistical data in an attempt to provide an epidemiological profile of the department. Yet in the Diffa Department, having both an epidemiologist and a public health physician backstopping the project from the national level who at times are directly involved in department-level activities, no effort was made to develop a more reliable data information system for the department. Collection of such data has direct bearing on the strengthening of statistical services at the national level. The evaluation team notes that although an initiative of this nature would have provided decision-makers with feedback on project performance, such an initiative would have to be at the discretion of the DDS of each department. In the Diffa Department, fairly reliable data collection is going on only with respect to hospital activities.

The Implementation Design refers to "village health teams". This concept indicates that the village health team worker, either a *secouriste* or a *matrone*, assists or complements the work of the other. In some instances there are two *secouristes* in one village. The team observed that often there may be two *secouristes* in one village but only one shared medical kit. In these instances, we were not able to discern any division of labor or responsibilities. Their system of record-keeping generally appeared to be adequate. In all cases we found the *secouriste* and *matrone* performing duties commensurate with their training. We have no reason to conclude that in Diffa Department medicines are going to ends other than they for which they were intended.

We found also that the matrones and securistes function separately. The team concept, meaning in this instance a complementing of responsibilities and duties did not appear to be the case. Although unable to quantitatively verify the following observation since no data is available at the CM level, it is our opinion that the VHWs who are not paid civil servants are providing basic services in addition to those provided by the official government system. In other words, we have reason to believe that the services of the village health workers are affordable to the population they serve, increase the accessibility to health services by the population and increase the officially recognized coverage by approximately 5 to 15 per cent. In addition, the team observed that referrals were made by the village health workers to the next level of care. This was verified and confirmed.

Finally, the following pages explain more clearly each aspect of this project. However, it is the evaluation team's opinion that the AFRICARE project as designed was overly ambitious. Decision-making by Niamey-based AFRICARE staff having administrative responsibilities for Diffa staff was and continues to be an arduous task which has negatively affected the morale of the Diffa-based staff. The public health physician is far too removed from the actual scene of operations and thus his knowledge and experience is not put to best use in Diffa. Since the public health

physician is based in Niamey, his time is more absorbed with Ministry of Health administrative matters and demands often unrelated to the Diffa project. Although situated within the Division of the Ministry of Health which has responsibility for the formation of all health personnel in the country, the public health physician's skills related to the development and augmentation of public health curriculum has been minimally used.

14. Evaluation Methodology

The purpose of this evaluation is to assess the performance of the AFRICARE project. Additionally, the team was requested to apprise USAID and the Government of Niger of a mutually acceptable approach whereby the AFRICARE project activities will be absorbed into the national Rural Health Improvement (RHI) project.

The AFRICARE project was initiated in March 1977 for a three-year funding period to September 1980. Subsequent to the commencement of this departmentwide project, USAID initiated a national health project called the RHI project. The RHI project incorporates most of the goals and objectives of the AFRICARE project, but on a nationwide scale.

The evaluation took place over a four-week period of which two were spent in the department of Diffa. The evaluation team was composed of the following persons:

Mr. Sofo Mamane, Assistant to Project Director, RHI, MSP/AS  
Dr. Dorian Shillingford, AFRICARE  
Dr. George Jones, USAID, Public Health Advisor  
Mr. John McEnaney, Public Health Advisor, DSB/HEA,  
Washington, DC and principle evaluator.

Using the Henderson random sampling technique,<sup>2</sup> ten villages with securistes were selected for visits. The team travelled to each of the three arrondissements in Diffa. In carrying out the two-fold purpose of the evaluation, the team spoke to the following people:

1. Dr. Abdou Ibrahim, Director, RHI Project, MSP/AS, Niamey
2. Mr. Issa Camara, Director, Division of Training, Health and Nutrition, MSP/AS, Niamey
3. Mr. Ali Zourkaleyni Maïga, Assistant to Secretary General, MSP/AS, Niamey
4. Dr. André Delas, WHO Regional Representative, Niamey
5. Mr. Gerald Mills, AFRICARE Representative/Niger, Niamey
6. Mr. James Watkins, Administrative Officer, AFRICARE, Niamey
7. Dr. Michel Thuriaux, Epidemiologist at Medical School (EES), MSP/AS, Niamey
8. Mr. Jay Johnson, Director, USAID/Niger, Niamey
9. Mr. Murl Baker, Evaluation Officer, USAID/Niger, Niamey
10. Mr. Herb Miller, Program Officer, USAID/Niger, Niamey
11. Mr. James K. Bishop, Ambassador
12. Mr. Dennis Keough, DCM
13. Mr. and Mrs. Raymond Roberson, Mechanic, AFRICARE Project, Diffa
14. Dr. and Mrs. James Cahil, Gynecologist, AFRICARE Project, Diffa
15. Dr. Minor Hernandez, Surgeon, AFRICARE Project, Diffa
16. Dr. Nargoungou Abdoulaye, DDS, Diffa
17. Mr. Sidibé Amadou, Assistant DDS, Diffa
18. Dr. Eric Morin, Deputy DDS and Coordinator PMI, Diffa
19. Mr. Toga Namata, Director, Rural Animation, Diffa
20. Mr. Gapta Gasso, Assistant Director, Rural Animation, Diffa

<sup>2</sup> Random sampling selection technique developed by Dr. H. Henderson, Director of Expanded Program of Immunization, WHO, Geneva.

21. Mr. Akreba Ghabdou, Ministry of Planning, Diffa Representative, Diffa
22. Mr. and Mrs. Edward Ruche, Equipment Specialist, AFRICARE Project, Diffa
23. Captain Dandi Abarchi, Prefet, Diffa
24. Mr. Oumarou Alzouma, Hospital Director, Diffa
25. Mr. Mahamane Yahaya, Grandes Endemies Director, Diffa
26. Ms. Karen Martinson, Peace Corps Laboratory Technician, Diffa Hospital
27. Mr. Abba Bana, Dispensary Nurse, Gueskeru, Diffa Arrondissement
28. Two Secouristes, Toumour, Diffa Arrondissement
29. Two Matrones, Toumour, Diffa Arrondissement
30. Village Chief, Toumour, Diffa Arrondissement
31. Adjoint-Chef Ibrah, Government Administrator, Bosso, Diffa Arrondissement
32. Mr. Goni Moussa, Dispensary Nurse, Bosso, Diffa Arrondissement
33. Two Matrones, Bosso, Diffa Arrondissement
34. Five Matrones, Barwa, Diffa Arrondissement
35. Village Chief, Barwa, Diffa Arrondissement
36. One Matrone, Métimey, N'Guigmi Arrondissement
37. Two Secouristes, Métimey, N'Guigmi Arrondissement
38. Mr. Sani Nabair, Dispensary Nurse, N'Gourti, Diffa Arrondissement
39. Ms. Sue McCloskey, Peace Corps Volunteer Nurse, Director Nutrition Program, PMI, N'Guigmi Hospital
40. Mr. Alkassoum Agalih, Dispensary Nurse, Billaberim, N'Guigmi Arrondissement
41. Mr. Oumansu Mamane, State Nurse, CM, N'Guigmi
42. Mr. Mamane Sani, State Nurse, Director Central Hospital, Maine-Soroa
43. Director Rural Animation, Maine-Soroa
44. Mr. Morou Mahamadou, Sousprefet, Maine-Soroa
45. Secouriste, Garoua, Maine-Soroa Arrondissement
46. Village Chief, Garoua, Maine-Soroa Arrondissement
47. Village Chief, Nahi, Maine-Soroa Arrondissement
48. Village Chief, Adébour, Maine-Soroa Arrondissement
49. Matrone, Adébour, Maine-Soroa Arrondissement
50. Two Secouristes, Malam-Boulamari, Maine-Soroa Arrondissement
51. Village Chief, Malam-Boulamari, Maine-Soroa Arrondissement

52. Two Secouristes, Boudoum, Maine-Soroa Arrondissement
53. Village Chief, Boudoum, Maine-Soroa Arrondissement
54. Dr. Bako, DDS, Zinder
55. Mr. and Mrs. Lionel Peirre, AFRICARE, Mechanic for RHI, Zinder
56. Mr. Hassane Soumeila Maïga, Director, MNICAS, Zinder
57. Mr. Hamani Yari, Adjoint au Préfet, Zinder
58. Dr. Tankari, DDS, Maradi
59. Mr. Ibrahim Abdou, Assistant DDS, Maradi
60. Dr. Magagi, DDS, Tahoua
61. Mr. Ali Alfa Cissé, Assistant DDS, Tahoua
62. Mr. Dourfaye, Director, Division of Health Planning and Statistics (DIS), MSP/AS, Niamey
63. Mr. Ousseini Soumana, DIS, MSP/AS, Niamey
64. Mr. Laouel Kiari, DIS, MSP/AS, Niamey
65. Dr. Boubacar Yansambou, DDS, Dosso
66. Dr. Gerrit Schréy (Dutch), Assistant DDS, Niamey
67. Dr. Lamott (Belgian), Public Health, EES, MSP/AS, Niamey
68. Dr. Jeannée (Belgian), Public Health, EES, MSP/AS, Niamey
69. Mr. André Lobit, Assistant DDS, Tahoua
70. Mr. Ousseini Kaimana, VHT Supervisor, Zinder
71. Mrs. Mamane Aichata, Midwife, Niamey
72. Mr. Salmou Ganoua, Participant Niamey Seminar
73. Mr. Alkassoum Nahadjo, Chief of Alphabetization, Agadez
74. Mr. Naino Doega, Chief of Animation, Zinder
75. Mrs. Kansaye, Animator, Niamey Seminar
76. Dr. Eric Costa (Belgian), Assistant DDS, Agadez

It is to be noted that persons outside of Diffa, having responsibilities for the Rural Health Improvement Project were also interviewed since one of the tasks of this evaluation is to provide the USAID Mission with recommendations for integrating the Diffa Project within the RHI project. Also, if

possible, the team wanted to obtain some data on the functioning of the RHI project so as to enable it to draw some comparisons with the activities in Diffa. In addition, the MOH suggested that the team interview as many DDSs as possible both to make such a comparison and assist in developing a realistic evaluation protocol for the proposed RHI evaluation in 1981.

At the Tahoua conference in 1976 the GON defined what would be the tasks of village health workers uniformly throughout the country. The evaluation team used this theoretical framework in its review of village health worker activities in order to determine whether and to what degree the VEH/s in Diffa were able to adhere to this job description. The Tahoua conference also prescribed a fixed list of medications that would be distributed and sold by the VEW. This list was also compared with what we saw in Diffa.

In addition, the January 1977 Implementation Design and Preliminary Planning Data document submitted by AFRICARE to USAID/Niamey was the guideline document the team used to compare proposed with actual project outputs. Beginning on page 24 of this report is a detailed listing of the agreed-upon outputs of the Diffa project and the evaluation team's observations as to whether or not the project achieved what it set out to accomplish.

## 15. External Factors

The project envisioned the training of a number of Nigerien counterparts who would ultimately assume responsibility for the project at the end of three years. This was contingent upon the GON identifying and providing full-time counterparts to AFRICARE personnel. With respect to developing a stronger public health curriculum at ENSP and ENICAS, the GON would allow appropriate technical assistance in course design and curriculum development. The team feels that a major constraint of this project was that the GON, for whatever reasons, did not provide counterparts. Furthermore, after the arrival of the public health physician, the GON placed higher priorities on activities other than expansion of public health courses in the nurse training curriculum. In the AFRICARE evaluation plans for this project, six assumptions are noted that have an impact on the project, if success is to be achieved. They are subject to influence from external factors. The team's assessment of these assumptions follows.

### 1. Ministry of Health continues to give high priority to the development of improved health services to the rural population:

The GON is committed to the development of improved health services to its rural population that is approximately 90% of the country. Differences exist between AID and GON in the interpretation of this commitment into action. Given its clear lack of adequate manpower, the GON to

some extent relies on the direct provision of services by expatriate medical personnel. However, it is not AID policy to finance the provision of direct service; rather, AID's focus is on the training/supporting of host country personnel to provide such services.

2. Health personnel and communities recognize the need for community participation in the delivery of health services:

On one hand it is our impression that health personnel are keenly aware of the necessity of obtaining community participation. On the other hand there is very little documented evidence that communities are requesting the services of VHWs. We were advised by 2 DDSs that this has just been a recent phenomenon. We are of the opinion however that this assumption is still valid.

3. Financial resources for health sector activities are not reduced, but increase in real terms as the economy grows:

According to the 1979-1983 Five-Year Plan just released, financial resources for the health sector are estimated to be about 9% per year of the total GON budget (during the next 5 years). Up from 5% over the last 3 years, this means that the government still considers health as an important sector in its overall development plans. What is of concern is where these funds will be focused. It is our impression that a shift is being made from VHT activities to strengthening the mobile medicine teams.

Currently, with the emphasis on supervisory visits, the AFRICARE project, (and also the RHI project) is gasoline-dependent, thus negating attempts to minimize high recurrent costs. We are concerned because at this time it is not clear how the MOH will portion out its budget allocation - now that AFRICARE (and RHI) will be recommending a greater share of resources to maintain mobility, as also will the Mobile Medicine Program.

4. Faculties recognize the need for public health curricula, in-service education and field supervision and collaborate in the design, implementation and evaluation:

Recognition of the need for public health curricula is a valid assumption, however it does not appear to be a GON priority. For state nurses, in three years of training, which is 1,891 training hours, 215 hours are spent in learning public health principles and an additional 25 hours in practical public health training. And these 25 hours are in year one!<sup>3</sup> For certified nurses, those who need public health training the most, of 560 hours of training, 42 are devoted to principles of public health and a meager 20 additional hours are spent in practical training. There is no practical training in hygiene, sanitation or microbiology! We are led to conclude that some aspects of this assumption, i.e. in-service education, appear to have a higher priority to the GON at present.

<sup>3</sup> The AFRICARE public health physician also noted that during their last year of training, each student is obliged to spend 3 months in practical training. This is usually done in Niamey or Dosso, since the students can be close to their monitors who live in Niamey. These 3 months are spent in preparing what is called "mémories", somewhat like our thesis. The student may choose a subject of his choice, according to the AFRICARE representative, this is generally a public health topic, (however this was not verified), works at the CM for 3 months, writes his thesis and defends it at the end of this course.

5. That all levels of health personnel will cooperate in reporting required data:

Reporting is obligatory, from the dispensary level to the ministerial level. Reports are sent weekly to the Division of Health Planning and Statistics in the Ministry. AFRICARE personnel have greatly assisted this unit in improving its reporting and analysis. However, no counterpart has been trained to assume operational responsibility for this Division. Also there continues to be a Belgian epidemiologist who directs these activities. This assumption is valid.

6. That there will be collaboration and cooperation among ministries for maximum benefits of integrated planning and services:

In any bureaucracy this is a problematic area. So too in Niger. There has been an interministerial council established to do planning as a "team". Important for this project, however, is the collaboration and cooperation of the various divisions within the Ministry of Health itself. The team failed to see close collaboration and cooperation between MOH services in the Diffa Department. For instance, the Mobile Medicine teams function as a vertical program, are self-sufficient in personnel, vehicles and fuel and have their own planning system. The dispensary nurse often does not know about their proposed itinerary and thus is handicapped in that many opportunities to gather villagers for immunizations are missed.

In N'Guigai, lack of coordination was demonstrated at the PMI. A growth chart is not provided for any child not born in the hospital. We did not see that AFRICARE knew about this practice or that the project attempted to address this problem.

We believe that some of these assumptions should be reviewed again with the MOH in order to better focus on some of the external constraints placed on a project such as AFRICARE and possibly the RHI project.

16. Inputs

This section examines the relationship of what AFRICARE, the GON or USAID proposed to provide by way of personnel, commodities or training into the project. The following matrix provides a clear understanding of this aspect of the program.

<u>Personnel</u>	<u>AFRICARE</u>		<u>GON</u>	<u>USAID</u>
	<u>proposed</u>	<u>actual</u>		
1. Public Health Doctor	2 yrs	3 yrs	no counterpart	Public Health Advisor-Liaison
2. Epidemiologist	3 yrs	3.2 yrs	no counterpart	N/A
No. 1 - 21 months				
2 - 17 months				
3. Surgeon	3 yrs	2 yrs	no counterpart ( trainees)	N/A
4. Gynecologist	2 yrs	2 yrs	no counterpart ( trainees)	N/A
5. Mechanic	3 yrs	3 yrs	no counterpart	N/A
6. Maintenance Technician			no counterpart	After inspection tour, advises re team concerns and needs
No. 1				
2				
7. Administrative Officer, Niamey	3 yrs		N/A	
8. Secretary, Niamey	3 yrs		N/A	
9. Project Coordinator, Washington, DC	3 yrs		N/A	Received reports and advises on pro- ject progress. Received debriefings during 3 years of project.
<u>Vehicules</u>		11		
<u>Construction</u>				
DDS buildings		yes		
Garage		yes		

<u>Materials</u>	<u>AFRICARE</u>	<u>GON</u>	<u>USAID</u>
Office for Public Health Doctor		yes	
Health Centers	equipment		
MCH Clinics	equipment		
Mobile Medecine Teams	equipment		
Environmental Sanitation	equipment		
Hospital	yes		
Garage	yes		
<u>Training</u>			
<u>Training, in-service</u>			
<u>Supervision of VHTs</u>		yes	
<u>Health Meetings and Seminars</u>	yes		
<u>Short Term Consultants</u>	no		
<u>Project Management</u>	Team leader for only 17 months		

Personnel arrived at various times during the project. In effect, the full project team has only been operational since 1978.

The GON, although providing assistance through the furnishing of office space for the two technicians in Niamey, and housing for the 4 technicians in Diffa, did not designate Nigerian full-time counterparts for the project.

The project document does not include a job description for technicians and physicians assigned to it. Neither does it provide a description of the management functions of the team leader. Personnel activities described in project and letters of appointment (MOH) served as job descriptions.

Because we did not interview Washington-based AFRICARE staff, the team is unable to provide any information as to the effectiveness in carrying out the project implementation plan of the AFRICARE Washington Project Coordinator. As a 6-person team, the position of Administrative Officer was justified. However, the personnel and housing problems existing in Diffa, raises the question of appropriate utilization of this position. The public health physician was expected to assume these responsibilities, a role for which he was not hired.

## 17. Outputs

This section measures actual progress against projected target outputs in the project design and implementation plan. Where outputs are on target, this is duly noted. In instances where targets are missed, the team has provided comments.

<u>Implementation</u>	<u>Implementation Target</u>	<u>Comments</u>																																				
1. Public Health Programs developed to shift emphasis from to curative to preventive health services.	A. Program of School Education, MCH, Health and Nutrition Ed, Environmental Sanitation are 100% operational in Diffa Department by end of year 3.	A. Recently teachers have been trained to provide first aid and health education to schools. MCH services were being delivered at all health centers. Concerning environmental sanitation, AFRICARE has financed the construction of latrines, at primary schools and health centers. However it had no input in the design and construction which was faulty and reduced effective use of these latrines.																																				
2. Trained cadre of volunteer village health personnel actively providing care	A. 32 VHTs trained in yr 1 65 VHTs trained in yr 2 96 VHTs trained in yr 3	A. This numerical goal was surpassed. The number of secouristes trained was 151. The number of matrones trained was 145. In addition to AFRICARE's role of financing the training program, the public health doctor and the gynecologist also participated in the training programs from time to time.																																				
3. Development of training guides for VHTs, sanitation aides and vehicule mechanics	A. 4 training guides designed and in use by end of yr 1.	A. Team only saw a vehicule mechanics' guide. This was written and was distributed by the AFRICARE technician to any driver who came to the garage for assistance, in addition to his own assistants.																																				
4. In-service Education Seminars for all health personnel in Diffa Department: Arrondissement level - 2d/3m Department level - 4d/3m National level -15d/6m	A. 1 seminar for each level, yr 1 3 seminars for each level, yr 2 4 seminars for each level, yr 3 (evaluation team observation "not possible")  Total: 24 seminars	<table border="1"> <thead> <tr> <th></th> <th>1987</th> <th>1988</th> <th>1989</th> <th>1990</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>2</td> <td>4</td> <td>4</td> <td>2</td> <td>12</td> <td>12</td> </tr> <tr> <td>1</td> <td>0</td> <td>1</td> <td>0</td> <td>2</td> <td>2</td> </tr> <tr> <td colspan="5"><hr/></td> <td></td> </tr> <tr> <td>3</td> <td>4</td> <td>5</td> <td>2</td> <td>14</td> <td></td> </tr> </tbody> </table> <p>In late 1979, AFRICARE began to participate in seminars, eg. WHO, RHIP, rather than finance them.</p>		1987	1988	1989	1990	Total	0	0	0	0	0	0	2	4	4	2	12	12	1	0	1	0	2	2	<hr/>						3	4	5	2	14	
	1987	1988	1989	1990	Total																																	
0	0	0	0	0	0																																	
2	4	4	2	12	12																																	
1	0	1	0	2	2																																	
<hr/>																																						
3	4	5	2	14																																		

Implementation

5. Plan and Schedule of supervision in operation:

Rural Clinic level - 6d/m  
Arrondissement level - 5d/m  
Department level - 5d/m  
Training Institution -10d/6m

6. Design, Implementation and Evaluation of a national retraining program for all health personnel

Implementation Target

A. Plan of supervision designed

Supervisional schedule operation:  
(18) 6 visits by each level yr 1  
(27) 9 visits by each level yr 2  
(36) 12 visits by each level yr 3  
(81) Total

Training Institution level:  
1 visit by end of yr 1  
2 visits by end of yr 2  
2 visits by end of yr 3  
5 visits Total

A. Design of retraining programs for:  
VHT

Registered Nurses  
Practical Nurses  
Midwives  
Doctors

Retraining program for VHTs implemented by end yr 1  
Retraining program for registered nurses implemented by yr 2  
Retraining program for practical nurses implemented by yr 3

Comments

A. The DDS in Diffa notes in his annual report for 1979 that no supervisory visits were made in 1978 and that about 2 or 3 were made by each CM in 1979. Our observation was that dispensary nurses were having difficulty in maintaining a regular supervisory schedule but that the CMs were visiting the dispensaries and some villages more frequently than in 1979. AFRICARE has receipts for supervisory visits that allegedly were made in Diffa. This information conflicts with the DDS' report. AFRICARE however was not able to report the number of visits their receipts represented.

Done  
yes - seminar level  
partly - only in hospital  
no  
partly - only at national seminar level  
yes  
yes  
no

<u>Implementation</u>	<u>Implementation Target</u>	<u>Comments</u>
7. Training in diagnostic laboratory techniques	A. 6 hrs/wk instruction at nursing school by yr 1 4 hrs/wk instruction at laboratory school by yr 2 On the job training for laboratory personnel at the national hospital in Niamey and Zinder by yr 1	N/A
8. Procedures for analyses, interpretation and utilization of epidemiological data	A. System for analyses, interpretation and utilization of EPI data by yr 1	yes
9. Semi-annual EPI Bulletin	A. 1 issue by yr 1 2 issues by yr 2 3 issues by yr 3	no no yes
10. Infrastructure organized which is capable of delivery of health service to rural areas	A. Official infrastructure approved and organized by end of first 6 months	It is team's opinion that GON already had the infrastructure approved and organized prior to project. AFRICARE assisted in pinpointing responsibilities of persons within infrastructure.
11. Technical Assistance in design, implementation and evaluation of public health programs	A. 6 project personnel Consultants Consultants	A. Provided. However, apart from the public health physician posted in Niamey, these personnel were not public health. Team saw no evidence of any evaluation apart from one in April 1980 done by a representative of AIDs auditor.
12. Technical Assistance in preventive and curative health care		1 public health physician 1 gynecologist 1 surgeon
13. Technical Assistance in production of health education materials		The public health physician acted as an advisor to various MOH committees responsible for developing health education materials.

<u>Implementation</u>	<u>Implementation Target</u>	<u>Comments</u>
14. Technical Assistance in designing curricula seminars retraining manuals training manuals		no yes no evidence to this effect no evidence to this effect except mechanics' training manual
15. Technical Assistance in design of procedures for analyses, interpretation and utilization of EPI data		yes
16. Technical Assistance in vehicle maintenance and repairs		yes
17. Technical Assistance in Maintenance equipment		yes
18. Short-term consultant assistance in evaluation of project activities		none
19. Short-term consultant on building construction		provided by REDSO/W
20. Project Management		AFRICARE was to provide a team leader for purposes of directing efforts in line with project as designed. However he only remained for 17 months and was based in Niamey. Also, the team feels that the poor design of the project and no job descriptions for personnel made such leadership doubtful at best. Because of these factors the project lacked clear management direction in implementation.

Implementation

Implementation Targets

Comments

This lack of clear leadership may have contributed to AFRICARE going off in directions tangential to the general purposes of the project (eg. latrines building and well digging). It is the team's opinion that actions should have been taken early in the project which would have more clearly described personnel responsibilities and program direction. Thus, the inputs may have been met, but the implementation schedule and targets were not realistic and should have been redefined earlier in the life of the project.

It is readily apparent that this was an ambitious undertaking, especially to have only three years in which to accomplish these objectives. The major aspect of this project, namely, strengthening and developing the infrastructure within Diffa, was constrained by the public health expertise being based in Niamey, two long days by road from Diffa. The lack of a clearly defined role for the public health physician also reduced considerably his expected impact. In one sense he is in a position to influence decisions at the national level, but how such decisions impact on strengthening the services delivery system in Diffa was not made clear to the team.

The project was overextended to the extent that more adequate training and retraining programs were not conducted in Diffa and to the extent that AFRICARE did not concentrate its public health resources in Diffa to assist in integrating and strengthening existing services. The pincer strategy suggested in the Implementation Design Plan may have been more successful with additional personnel having public health backgrounds. Or simply with a more concerted effort in Diffa to develop a "model" system. What the evaluation team observed was an ongoing delivery system, i.e. services were being provided by VHWs at the village level, but almost as though it were another vertical program. A strong public health component at the Diffa level could have focused on this problem area and devoted more time and energy to integrating services at this level. We are of the opinion that

the other 6 departments of Niger are implementing similar programs and are indeed reaching rural populations. What is difficult to determine is what has the AFRICARE project done in Diffa that is any different or "better" than the other departments. Until an evaluation of the RHI project has been conducted, that question will have to wait for an answer.

18. Purpose

The purpose of the AFRICARE project is to strengthen and expand the existing health care system of the GON, especially in Diffa Department.

It is the evaluation team's opinion that this has generally been done. However, since the team did visit 4 other departments and interviewed each of the DDSs and their assistants, the team wishes to note that the strengthening and expansion of the rural health care system is a national priority. As such, activities are going on in the country, at the ministerial level, at the department level - which are contributing to this priority, irrespective of the AFRICARE efforts. In Diffa, it is the evaluation team's opinion that AFRICARE did exceedingly well in providing assistance for the development of an adequate logistics and supply system. Additionally, their efforts at providing adequate tertiary services to the population have served to bolster the curative aspect of the delivery system.

19. Goal/Subgoal

A. Increase the level of adequate and accessible basic health services in Diffa Department.

By increasing the numbers of VHTs through training secouristes and matrones, it is estimated that health care coverage by secouristes has been increased by about 20%, which is the equivalent of four rural dispensaries. Moreover, with the increase in trained matrones, it is estimated that an additional 20% of births are now known to the departmmt. This represents approximately half of the activity of the CM.

B. Strengthen public health training, in-service education and field supervision of health personnel.

The team saw no evidence that curriculum changes had been effected which augmented practical public health training in the nursing schools. However, eight seminars conducted by AFRICARE in Diffa provided much needed and usually neglected in-service education to health personnel. Additionally, supervisory visits appear to be becoming more systematic in Diffa. The team was impressed with the competency of the VEW to the extent that he understood which medications were for which symptoms. And most importantly, how to replenish and maintain an adequate supply of medications. At this level the system appeared to be functioning.

The team was concerned with the degree to which the VEW was able to identify the etiology, or cause of disease as well as its symptoms. Information as to the degree to which para-professional personnel can appropriately treat

the etiology of an illness is of concern to many professional medical observers. However, lack of data precluded useful exploration in this area. Generally, it is our opinion that symptoms and not etiology are treated at this level.

C. Strengthen the bureau of statistics in the MOH with epidemiological capability.

This goal was victim of the strengths of the AFRICARE personnel at the beginning of the project. Rather than concentrating on the development of an EPI unit, emphasis shifted to development of a standardized national diagnostic laboratory. Not until the first epidemiologist was replaced, did the project concentrate on this goal. In conjunction with a Belgian epidemiologist who directs the EPI unit, AFRICARE assisted the GON in strengthening and augmenting this unit.

D. Increase the capability of the MOH to deliver health services to the rural population, especially Diffa.

AFRICARE can only be rated outstanding in meeting this goal. The experienced auto-mechanic established a garage and all the ancillary operations to assure smooth functioning. All vehicles in the department (health sector) are maintained and functioning. This component has been so successful that other government agencies as well as private entrepreneurs bring work for the garage. Its reputation is even known in Cameroon! However, with the departure of the mechanic expected to occur in August, the team is not optimistic that the smooth functioning of this garage can be maintained.

**20. Beneficiaries**

The section attempts to analyse the numbers of persons who benefit directly from the project. Secondly an attempt is made to determine the number, who, as a result of the activities of this project, may have benefited.

<u>Direct:</u>	1. DDSs.....	1
	2. CMs.....	3
	3. Dispensary Nurses.....	12
	4. VEWs.....	151
	5. Matrones.....	145
	6. MOH (other than seminars).....	10
	7. Mechanics.....	5
	8. OB/GYN Patients.....	900
	9. Surgery Patients.....	700
	10. General Medecine.....	850
	11. Seminars, MOH personnel.....	800

Indirect:

Through the VHTs an additional 60,000 people are covered by the health system. Of these, 10-15% have actually consulted with a VHT.

Through the Matrones about 200 women received prenatal care that would otherwise not be available.

This project does not directly contribute to reducing rates of unemployment, however, the system does allow for securistes to sell their medicines at a small profit agreeable to the general village population. Although this is one form of an income producing activity the securiste must still maintain other sources of employment for income. Matrones, on the other hand, provide services which are usually rewarded with a small gift (usually in kind) from the family she assists.

## 21. Lessons Learned

It was noted earlier (p.12) that the purpose of this evaluation is to apprise USAID and the GON of a mutually acceptable approach to fuse the AFRICARE activities into the national Rural Health Improvement (RHI) project. Also, this evaluation is to assess the performance of the AFRICARE project. In this section we will present the team's observations in terms of what can be learned from the AFRICARE project. After which we will present recommendations for consideration by USAID and the GON concerning fusing the AFRICARE project with the RHI project.

### A. Lessons learned from AFRICARE project:

1. In order for both USAID and the GON to obtain maximum benefit from this project, or any project for that matter, USAID supported technicians should be provided with a Nigerien counterpart destined to remain in the project after the technicians leave. Failure to assure adequate counterpart training runs the risk of having the expatriate technicians become direct providers of services whereby community needs may be met and community expectations may rise. At the end of the technicians' contract, it is not only the GON that perceives the vacuum being created, but most importantly, community expectations are shattered and confidence in GON is diminished.
2. Design of a project with reasonable objectives couched in logical approaches lends itself more to success than overly ambitious rhetoric couched in ambiguity. Keep it simple.

3. Clear definition of what the project intends to do. By attempting to strengthen the health delivery system of the Government of Niger, the project was in over its head. By attempting to strengthen the health care system in Diffa Department, the project had a much better chance of success. However, the AFRICARE project seemed to be unsure of what it wanted to do and where it was going to do it. This lack of clarity in the original program design contributed in part to some missed opportunities.
4. Clear determination, before project initiation, as to the kinds of personnel deemed necessary to effect the stated purpose of the project. Not only was this not done, but due to the ambiguous purpose of the project, Diffa today has neither laboratory services, nor systematic epidemiological data gathering and no public health leadership.
5. Self-evaluation. Although the project set out to strengthen the health care delivery system in Niger and in Diffa, a scheduled self-evaluation mid-way through the project may have focused on the difficulties of this undertaking. In deed, the project may have believed that it was filling gaps that otherwise would not have been filled, but did this "gap" filling detract from the ultimate purpose of the project? Could AFRICARE have seen the value in concentrating it's public health resources in Diffa rather than isolating them in Niamey? To date, no valid statistical data is available on the three years of activity in Diffa. Quantative information on the numbers of VHVs trained and retrained, and the number of supervisory visits carried out, only superficially reflect what the project was supporting.

Opportunities may have presented themselves to develop a departmentwide reporting system which would better reflect the overall success of these infrastructure support activities by providing data on additional coverage, increased accessibility to health care and utilization by the community as a result of installing a village health worker.

6. USAID should not support a project which provides qualified technical assistance but is placed in a situation where such technical assistance do not participate in how USAID monies are spent in the project. Examples of this are numerous in the AFRICARE project. For instance: 1) no technical input into the latrine construction program; 2) no input into the supervision plan in Diffa in 1978; 3) no input into appropriate use and monitoring of equipment provided to the Mobile Medecine Team in Diffa; 4) no significant input into a plan for the appropriateness and reasonableness of purchasing the Berliet truck for Diffa; 5) little or no input into assisting and developing a departmentwide reporting system which would reflect some of the concerns noted in 5. above regarding VHWs.

7. Project should have decision-making capability within the project. The lines of communication from Diffa to Niamey to Washington are much too long and cumbersome. There was no one person responsible in Diffa for making decisions which directly affected project operations. Staff morale is adversely affected in relation to their distance from decision-making point.

8. Latrine construction programs do not succeed if initiated in a vacuum. It is not reasonable to assume that latrines will be used if the community is not involved in planning site location, type and general maintenance. Additionally, coupled with this planning and maintenance responsibility, systematic health education should be provided to prepare the village for latrines. There must be close coordination between all units involved in the project at the government level after the village has agreed to the building and maintenance plans.

In the case where a school latrine program is established, hygiene should be an integral aspect of the curricula. To expect the teachers to increase their teaching hours voluntarily is not realistic. Again, after integrating regular hygiene lessons into the curriculum, school principals and teachers should participate in site location and continued maintenance.

Where water is a scarce resource, and pit latrines can be constructed, the construction of aqua-privies should unequivocally be avoided.

9. USAID should assist in enhancing closer cooperation between project activities and Peace Corps manpower utilization. With the lack of adequate local manpower, Peace Corps programming efforts should be brought to the attention of both Peace Corps and the GON, so as to complement USAID project activities. This approach could help minimize Peace Corps from working in a vacuum.

10. Project activities which require collaboration with other government departments should be mutually worked out and agreed to in writing. For example, AFRICARE financed the well in Bosso, OFEDES built. However,

neither the MOH, or AFRICARE nor USAID nor the Bossa Administrator, nor the representative from the Ministry of Plan nor the Prefet know who is responsible for maintaining it. Also, one time events such as this should be avoided if not specifically tied in with project objectives.

11. Agreement should be obtained, in writing, between the project and the MOH as to who will provide what. At present, the MOH assumes that AFRICARE will absorb costs of any equipment the MOH approves for the hospital in Diffa. The DDS is also under the impression that the AFRICARE project will finance vehicle parts for the Departmental garage. The project has not adequately addressed this and thus this question remains open-ended. Also, any request for approved equipment and parts should be within approved plans for their use. For example, the recent request for a number of \$3000 microscopes for Diffa. The AFRICARE representative was not aware of any intention on the part of the DDS to make such a request and did not know where and how they would be used.

B. Concerning fusion of present activities into RHI project, the following recommendations are offered:

1. Terminate the AFRICARE project, as it is presently designed, in March 1981.

2. Advise GON that USAID will not support technicians and physicians to provide direct medical services and accordingly, will need to have assigned to the Diffa Department, a reasonable number of trainees for each technician and physician in order to justify their presence, i.e. surgeon, gynecologist, automotive repair technician, and bio-medical equipment repairmen.
3. The AFRICARE provided public health physician position could be absorbed into the technical assistance component of the RHI project. However, this should not be undertaken until a written job description has been developed and approved by USAID and the GON.
4. The RHI project will not pick up the services of the AFRICARE Administrative assistant or secretary. However, this may be left open to negotiation. In any event, if it is decided to include the Administrative Assistant and secretary, job descriptions must be developed and approved by both USAID and the GON. In addition, the contract must be amended to clearly reflect the organizational lines of communication and respective responsibilities of AFRICARE, USAID and the GON before finalizing the approval of supporting the Administrative position in the RHI project.
5. Owing to the stressful work and environmental conditions to be endured by personnel assigned to the Diffa region, the evaluation team recommends the provision for more respite trips to Zinder. Project should, in accordance with this recommendation, furnish a suitable vehicle and sufficient fuel.